

UHCCR 2

Office of the President
December 1, 2025

Members, Board of Trustees:

UK HEALTHCARE MEDICAL STAFF BYLAWS

Recommendation: that the Board of Trustees approve the UK HealthCare Medical Staff Bylaws, attached as Exhibit 1, as the amended and restated bylaws of the UK HealthCare Medical Staff.

Background: The University of Kentucky Governing Regulation GR II.G.8. establishes the University Health Care Committee to serve as the governing body and authority responsible for managing and operating the University's academic health system in accordance with applicable laws, rules, regulations and accreditation standards.

The University of Kentucky UK HealthCare Medical Staff Bylaws (Bylaws) govern the medical staff responsible for the quality of care, treatment, and services provided to the patients of UK HealthCare and the University of Kentucky Hospital and UK HealthCare Good Samaritan Hospital. The Bylaws were adopted and approved on October 11, 2010, and later amended and restated in 2012, 2016, 2019 and 2023. Since then, there has been a change in UK HealthCare leadership and operations. Therefore, on October 31, 2025, the UK HealthCare Medical Staff (approximately 1,284 members, which included the members of the Organized Medical Staff) and the UK HealthCare Medical Staff Executive Committee (17 members) were notified of a special meeting of the Organized Medical Staff (OMS), the voting members of the Medical Staff, on November 25, 2025, to consider a resolution to approve the amendments to the Bylaws marked in Exhibit 1. The amendments reflect updates to the medical staff privileging process, administrative organization, various other edits to reflect updated Joint Commission standards and terminology, and improve consistency throughout the document. (See Executive Summary below.) The notification included (i) the revised copy of the Bylaws set forth in Exhibit 1; (ii) an executive summary of the amendments; (iii) information concerning the OMS membership and voting process; and (iv) contact information for questions.

On November 14, 2025, the OMS (304 members) were reminded of the special meeting on November 25, 2025, to consider this same resolution. The notification included (i) the revised copy of the Bylaws set forth in Exhibit 1; (ii) an executive summary of the amendments; (iii) instructions for voting electronically; (iv) the agenda item, which consisted only of the resolution; (v) the right to and process for proposing an amendment for consideration at the next annual or special meeting of the OMS;

and (vi) contact information for questions. The OMS consists of the following medical staff members of the Active Faculty and Active Community categories determined not more than thirty (30) calendar days before delivery of the notice of the meeting:

- A Chief Medical Officer (CMO) and each Associate and Assistant Chief Medical Officer;
- All Chairs;
- Each medical director appointed by the CMO upon consultation with the appropriate Chair and approved by the Chief Physician Executive, with funding provided through the CMO Office and an express allocation of effort for medical director duties;
- Each service line, section and division chief;
- Each elected officer of the Medical Staff;
- Each University of Kentucky or UK HealthCare center director;
- Each member of the Medical Staff Executive Committee, the Medical Staff Operating Subcommittees, the Peer Review Committee and the Credentials Committee who is a member of the Medical Staff;
- Each chair of the other Medical Staff Standing Committees identified in the Bylaws who is a member of the Medical Staff;
- Each residency program director; and
- The Chief Clinical Officer.

On November 25, 2025, the OMS approved the Bylaws amendments.

On November 25, 2025, the Medical Staff was notified the OMS had adopted the resolution amending the Bylaws as marked in Exhibit 1, subject to the approval of the University Health Care Committee, which has final legal authority.

A high-level overview of the amendments is provided in the executive summary provided below.

Action taken: Approved Disapproved Other _____

Executive Summary

A. Updated Processes for Medical Staff Affairs Office, including Peer Review

The proposed amendments transfer to a department-level policy the focused review of clinical privileges and ongoing professional practice evaluations conducted by the Medical Staff Affairs Office. These reviews identify trends and ensure quality of care and patient safety. Additionally, the proposed amendments refine the process that the peer review committee uses to support, intervene, and perform designated professional review functions of the medical staff members. (For key provisions, see Articles 7 and 8).

B. Updates to UK HealthCare Administrative Organization

In 2023, Dr. DiPaola, as Chief Clinical Officer and Co-EVPHA, and Dr. Monday, Co-EVPHA, eliminated the Chief Physician Executive position. The Executive Chief Medical Officer position was created in part to perform the Chief Physician Executive functions. In addition, UK HealthCare added a Chief Operating Officer in 2025. The proposed amendments match current executive leadership for UK HealthCare. (For key provisions, see Definitions).

C. Revisions to Reflect Changes in the Medical Staff Executive Committee and Officers of the Medical Staff

The Medical Staff Executive Committee (MEC) is charged with the delegated responsibility from the Medical Staff and the University Health Care Committee for self-governing the members of the Medical Staff, and for overseeing the performance of clinical programs including the quality, safety and efficiency of care and treatment. The proposed amendments remove the Vice President positions for each of the Hospitals and instead include a President-Elect and a role for the Past President. In addition, the proposed amendments change the composition of the MEC to add three at-large members and the Chair of the Peer Review Committee, reflect changes in the officers of the Medical Staff, and update the ex officio members without vote (For key provisions, see Article 12).

D. Revisions to Streamline the Categories of the Medical Staff

Various edits are proposed to divide the Medical Staff into categories denominated Active Faculty, Courtesy, Voluntary, Clinical Fellow, University Health, and Honorary. The categories of Active Community and Associate are removed and subsumed by other categories without changing the Medical Staff makeup. (For key provisions, see Article 3).

E. Revisions to Reflect Shared Leadership Among UK Chandler Hospital and Good Samaritan Hospital

Various edits are proposed to eliminate separate positions for Good Samaritan Hospital medical staff members and UK Chandler Hospital medical staff members. Rather than support two separate meetings, each hospital's interests and concerns are brought to the MEC at one time. (For key provisions, see Article 3 and 12).

F. Revisions to Reflect Previous Amendments Since 2010

Edits are proposed to reflect the adoption of amendments to the Bylaws since 2010.

UNIVERSITY OF KENTUCKY

UK HEALTHCARE MEDICAL STAFF BYLAWS

ADOPTED AND APPROVED

OCTOBER 11, 2010

AMENDED AND RESTATED

XXX

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UK HEALTHCARE MEDICAL STAFF BYLAWS

PREAMBLE

The University of Kentucky owns and operates, as part of UK HealthCare, the University of Kentucky Hospital and UK HealthCare Good Samaritan Hospital.

The licensed clinicians authorized to practice within UK HealthCare and the Hospitals are organized into the UK HealthCare Medical Staff in conformity with these Bylaws. The Medical Staff is responsible for the quality of care, treatment and services provided to the patients of UK HealthCare and the Hospitals.

Subject to the final authority and approval by the University Health Care Committee of the University of Kentucky, the Medical Staff shall exercise such self-governance and power reasonably necessary to discharge its responsibilities under these Bylaws (which shall not be considered to be a contract).

ARTICLE 1

DEFINITIONS

The following capitalized terms will have the meanings set forth in this Article, unless the context clearly indicates otherwise.

ACGME

ACGME refers to the Accreditation Council for Graduate Medical Education.

Administration

Administration refers to the Chief Clinical Officer, the Executive Chief Medical Officer, the Chief Nurse Executive, the Chief Operations Officer, the Executive Vice President for Health Affairs, the Vice President for Ambulatory Services and Medical Group Operations, and their respective offices and staff.

Board of Trustees or Board

Board of Trustees or Board refers to the University of Kentucky Board of Trustees.

Chair

Chair refers to a Chair of a clinical department in the College of Medicine, College of Dentistry, or College of Public Health at the University of Kentucky. For purposes of these Bylaws, the Director of the Lucille Markey Cancer Center shall also be considered to be a Chair.

Chandler Hospital

The University of Kentucky Hospital is referred to in these Bylaws as “Chandler Hospital” and is the tertiary care, teaching, medical, surgical, adult and pediatric care hospital owned and operated as an operating division of and by the University of Kentucky.

Chief Clinical Officer¹

The Chief Clinical Officer is the University of Kentucky officer responsible for all of UK HealthCare operations, including enterprise management of clinical services (Chief Medical Officer(s), Nursing, Customer Service, and Clinical Operation Finances), information and support services, recruitment and retention of staff, physical and financial assets, and the various UK HealthCare clinical units (Chandler Hospital, Good Samaritan Hospital, and ambulatory clinical services). The Chief Clinical Officer shall be a physician and is selected by the University Health Care Committee upon the recommendation of the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. For purposes of Hospital accreditation and the Conditions of Participation (CoPs), the Chief Clinical Officer is designated as the chief executive officer of the Hospitals. The appointment is administrative and may be removed at any time at the sole discretion of the University Health Care Committee. In the event of a vacancy in this position due to resignation or removal, the Executive Vice President for Health Affairs and/or designee shall serve as Interim Chief Clinical Officer until a new appointment is made.

Chief Medical Officer(s)

The Executive Chief Medical Officer may appoint more than one Chief Medical Officer, subject to the required approvals, and distribute the duties and responsibilities of the Chief Medical Officer to each appointee as appropriate. If more than one Chief Medical Officer is appointed, the Chief Medical Officer as used in these Bylaws refers to the Chief Medical Officer appointed by the Executive Chief Medical Officer to perform specific duties, responsibilities or functions. The appointment is administrative and may be removed at any time at the sole discretion of the Executive Chief Medical Officer. The Office of the Executive Chief Medical Officer or “CMO Office” is comprised of the Executive Chief Medical Officer and Chief Medical Officer(s). The CMO Office also includes the Office of Advanced Practice. A Chief Medical Officer, in addition to duties and responsibilities otherwise described in these Bylaws, shall assist in coordinating the activities of the Administration, the nursing staff, and other non-physician patient care services with those of the Medical Staff.

Chief Nurse Executive²

The Chief Nurse Executive is the chief nursing officer for the Hospitals, the University ambulatory locations and the University health care enterprise. The Chief Nurse Executive is appointed by the Chief Clinical Officer upon the recommendation of the Chief Operating Officer, subject to the approval of the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. The appointment is administrative and may be removed at any time at the sole discretion of the Chief Clinical Officer.

¹ EP4 LD.01.03.01; EP1 & EP5 LD.01.04.0

² EP5 LD.01.04.01; EP3 NR.01.01.01

Chief Operating Officer

The Chief Operating Officer is the chief administrator for the Hospitals and is appointed by the Chief Clinical Officer to act on his/her behalf in the overall management of the Hospitals. The appointment is subject to the approval of the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. The appointment is administrative and may be removed at any time at the sole discretion of the Chief Clinical Officer.

Chief Quality and Safety Officer

The Chief Quality and Safety Officer is responsible for oversight and improvement of patient safety and enterprise quality and safety initiatives. The Chief Quality and Safety Officer is appointed by the Executive Chief Medical Officer, subject to the approval of the Chief Clinical Officer and the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. The Chief Quality and Safety Officer may appoint more than one Associate Chief Quality and Safety Officers, subject to the required approvals, and distribute the duties and responsibilities of the Chief Quality and Safety Officer to each appointee as appropriate. The appointment is administrative and may be removed at any time in the sole discretion of the Executive Chief Medical Officer.

CoPs

The Conditions of Participation in Medicare set forth in Part 482 of Title 42 of the Code of Federal Regulations are referred to in these Bylaws as the “CoPs.”

Credentials Committee

The Credentials Committee is the standing committee of the Medical Staff which is responsible for reviewing the application packages for initial appointment and reappointment to the Medical Staff and the Health Professional Staff and requests for clinical privileges, and for recommending action on such packages and requests to the Medical Staff Executive Committee (MEC) and the University Health Care Committee acting as the governing body.

Executive Chief Medical Officer

The Executive Chief Medical Officer is responsible for overseeing the clinical practice, Chief Medical Officer(s), CMO Office, clinical quality, and patient safety. The Executive Chief Medical Officer is responsible to and directly consults with the Administration and the University Health Care Committee for the quality and efficiency of clinical services and professional performance in UK HealthCare and the effectiveness and quality of patient care periodically throughout the fiscal year but in no event less than twice a year. The Executive Chief Medical Officer is appointed by the Chief Clinical Officer, subject to the approval of the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. The appointment is administrative and may be removed at any time at the discretion of the Chief Clinical Officer upon approval of the Executive Vice President for Health Affairs.

Executive Vice President for Health Affairs

Pursuant to UK Governing Regulation Part VIII and UK Administrative Regulation 1:1.IV.C, the Executive Vice President for Health Affairs is appointed by the Board of Trustees, acting upon recommendation of the President of the University, as the chief operating officer for the

University's health care enterprise. The Executive Vice President for Health Affairs is responsible for the planning, development, and operations of the health care enterprise, according to the priorities established by the President and the Board of Trustees. The clinical enterprise encompasses and integrates all the patient care activities of the University. The appointment is administrative and may be removed at any time at the sole discretion of the Board of Trustees.

Fair Hearing Plan

The Fair Hearing Plan is the procedure described in ARTICLE 9 of these Bylaws for hearings and appeals of Professional Review Actions.

GSA List

GSA List refers to the General Service Administration List of Parties Excluded from the Federal Programs.

Good Samaritan Hospital

UK HealthCare Good Samaritan Hospital is referred to in these Bylaws as "Good Samaritan Hospital" and is the community-based teaching, medical, surgical adult care hospital owned and operated as an operating division of and by the University of Kentucky.

Governance Documents

The Governance Documents include these Bylaws, UK HealthCare policies and procedures, the Behavioral Standards in Patient Care, the Ethical Principles and Code of Conduct of the University of Kentucky, the University of Kentucky Code of Conduct Addendum, the UK HealthCare Corporate Compliance Program, the UK Governing Regulations and the UK Administrative Regulations.

HCQIA

HCQIA refers to the Health Care Quality Improvement Act of 1986, as amended.

Health Professional Staff

The Health Professional Staff is comprised of the licensed practitioners other than physicians and dentists who are credentialed and privileged to provide health professional services to patients at the Hospitals within the scope of their respective licenses and delineated privileges. Health Professional Staff provide services under the supervision of an Active Medical Staff member. Their privileges are strictly limited to the performance of specialized clinical services within the field of the member's competence, as specifically designated by individual.

HIPAA

HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder, each as amended.

Hospital

Hospital refers to each of Chandler Hospital and Good Samaritan Hospital. For purposes of the Centers for Medicare and Medicaid Services provider-based determination, Chandler Hospital is the main provider, and Good Samaritan Hospital is a provider-based remote location of the main provider.

Medical Staff

Medical Staff refers to the UK HealthCare Medical Staff, the single, self-governing body, comprised of all licensed medical physicians and dentists who have been appointed to the Medical Staff in accordance with these Bylaws and are privileged to attend patients at the Hospitals. The Medical Staff is an integral part of the University of Kentucky, UK HealthCare, and the Hospitals and is not a separate legal entity.

Medical Staff Affairs Office

The Medical Staff Affairs Office is the administrative entity within UK HealthCare supporting the Organized Medical Staff and facilitating the work of medical staff committees, including the Medical Staff Executive Committee. The Medical Staff Affairs Office ensures the smooth operation of the medical staff governance processes and promotes compliance with regulations.

Medical Staff Executive Committee (MEC)

The MEC is the executive leadership committee of the Medical Staff.

OIG Sanction Report

OIG Sanction Report refers to the U.S. Department of Health & Human Services, Office of Inspector General's List of Excluded Individuals, as published from time to time.

Organized Medical Staff³

Organized Medical Staff refers to the members of the Medical Staff in the Active Faculty categories who are entitled to vote. The exercise of authority of the Organized Medical Staff is subject to the final authority and approval by the University Health Care Committee and the Board of Trustees.

Patient Encounter

A Patient Encounter means an inpatient admission, establishment of an observation case, a patient consultation, or an outpatient procedure, excluding the technical component of such clinical services.

Peer Review Committee

The Peer Review Committee is a standing subcommittee of the MEC that has been delegated the authority to oversee and be responsible for the safety and quality oversight activities of the Medical Staff and the Health Professional Staff, including, but not limited to, focused reviews, ongoing professional practice evaluations and general peer review activities.

Licensed Practitioner⁴

Licensed practitioner refers to any of a physician, dentist, oral surgeon, physician assistant, nurse practitioner, including certified registered nurse anesthetist, advanced practice registered nurse,

³ EP17 MS.01.01.01

⁴ The Joint Commission defines licensed practitioner as "An individual who is licensed and qualified to direct or provide care, treatment, and services in accordance with state law and regulation, applicable federal law and regulation, and organizational policy."

certified nurse midwife, and clinical nurse specialist, licensed clinical social worker, clinical psychologist, podiatrist and such other licensed practitioner whose practice of his/her profession at a Hospital is subject to credentialing and privileging as set forth in these Bylaws.

President of the Medical Staff

The President of the Medical Staff serves as the chief officer and representative of the Medical Staff.

Privileging Subcommittee(s)

A Privileging Subcommittee is a subcommittee of the Credentials Committee that may be delegated the authority to assess and delineate clinical privileges to Practitioners granted appointments to the Medical Staff and the Health Professional Staff, subject to review, ratification and final approval by the Credentials Committee, the MEC, and the University Health Care Committee acting as the governing body.

Professional Review Activity

A Professional Review Activity is an activity of UK HealthCare with respect to a physician or other licensed practitioner: (1) to determine whether the Practitioner may have clinical privileges with respect to the Hospitals or membership in the Medical Staff; (2) to determine the scope or conditions of such clinical privileges or membership; or (3) to change or modify such clinical privileges or membership.

Professional Review Action

A Professional Review Action is an action or recommendation of UK HealthCare: (1) taken in the course of a Professional Review Activity; (2) based on the professional competence or the conduct of a licensed practitioner which affects or could adversely affect the health or welfare of a patient or patients; and (3) which adversely affects or may adversely affect the clinical privileges of the practitioner. The term “adversely affect” includes a reduction, restriction, suspension, revocation, denial or failure to renew clinical privileges or Medical Staff membership.

Third-Party Service

The Third-Party Service is a third-party centralized clinical credentialing service engaged by the University of Kentucky through the Medical Staff Affairs Office to assist in the verification of credentials.

UK HealthCare

UK HealthCare refers to the healthcare delivery and clinical programs of the University of Kentucky Colleges of Medicine, Dentistry, Nursing, Pharmacy, Health Sciences, and Public Health, their affiliated faculty practice plans, University of Kentucky Hospital, UK HealthCare Good Samaritan Hospital, UK HealthCare Ambulatory Services and related support organizations and programs.

University Health Care Committee

The University Health Care Committee is a standing committee of the Board of Trustees. The University Health Care Committee is designated by the Board of Trustees as the governing body of UK HealthCare and the Hospitals for all purposes, including accreditation and the

CoPs. The University Health Care Committee has the ultimate authority and responsibility for the oversight and delivery of health care by the Medical Staff and the Health Professional Staff.

University or UK

The University of Kentucky, an agency of the Commonwealth of Kentucky, is a publicly supported institution of post-secondary education established and maintained pursuant to Chapter 164 of the Kentucky Revised Statutes and is sometimes referred to in these Bylaws as “UK.”

President-Elect

President-Elect serves as the second-ranking officer of the Medical Staff and assumes the duties of the President in his or her absence. The President-Elect also acts as an administrative officer and representative of the Medical Staff, supporting the President in leadership responsibilities and preparing to assume the role of President at the end of the term, unless otherwise specified.

Vice President for Ambulatory and Medical Group Operations

The Vice President for Ambulatory Services and Medical Group Operations is the chief administrator for UK HealthCare ambulatory services and is appointed by the Chief Clinical Officer to act on his/her behalf in the overall management of UK HealthCare ambulatory services. The appointment is subject to the approval of the Executive Vice President for Health Affairs with subsequent approval of the Board of Trustees in accordance with standard procedures for similar positions at the University. The appointment is administrative may be removed at any time at the sole discretion of the Chief Clinical Officer.

ARTICLE 2

PURPOSE

2.1 Medical Staff Purpose

The Medical Staff, appointed by the University Health Care Committee, is intended to provide an organization through which individual physicians and dentists may obtain the benefits of association with UK HealthCare and the Hospitals and fulfill the obligations of the Medical Staff membership. The Medical Staff, organized pursuant to these Bylaws, is a group of physicians and dentists licensed to practice under the laws of the Commonwealth of Kentucky. The Medical Staff is responsible for the quality of all medical care, treatment and clinical services provided to patients within UK HealthCare and at the Hospitals and for the ethical and professional practices of its members. The Medical Staff is accountable to the University Health Care Committee for these functions. In addition, the Medical Staff is established for the following purposes:

2.1.1 To provide that all patients, regardless of economic or social status, race, color, ethnic origin, national origin, creed, religion, political belief, gender, sexual orientation, marital status, age, disability, service in the armed forces or any other reason prohibited by law or UK HealthCare policy, receive continuous, quality medical care from

Practitioners appointed to the Medical Staff that is commensurate with acceptable standards and available community resources; and

2.1.2 To advance medical knowledge and provide an educational setting that will support the mission, vision and mandates of the University of Kentucky and UK HealthCare in research and education and assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill.

2.2 Organized Medical Staff Purpose

The Organized Medical Staff oversees the quality of patient care, treatment and services provided by Practitioners throughout UK HealthCare.⁵ The Organized Medical Staff is accountable to the University Health Care Committee for this function. In addition, the Organized Medical Staff is established for the following purposes:

2.2.1 To provide leadership in activities related to patient safety, including measuring, assessing and improving processes that primarily depend on the activities of one or more members of the Medical Staff and/or Health Professional Staff;⁶

2.2.2 To provide oversight in the process of analyzing and improving patient satisfaction;⁷

2.2.3 To monitor the quality of medical histories and physical examinations;⁸

2.2.4 To maintain and enhance the professional performance of all Practitioners appointed to the Medical Staff through ongoing review, evaluation, and improvement of clinical performance;⁹

2.2.5 To formulate, adopt and amend Bylaws and policies for the proper functioning of the Medical Staff, subject to the approval of the University Health Care Committee;¹⁰

2.2.6 To assist the University Health Care Committee by serving as a professional review body in conducting Professional Review Activities;¹¹ and

2.2.7 To organize the activities of Practitioners in the Hospitals in order that they may carry out, in conformity with these Bylaws, the functions delegated to them by the University Health Care Committee.

⁵ EP1 MS.03.01.01; EP3 MS.03.01.01

⁶ EP4 MS.03.01.01; EP1 MS.05.01.01

⁷ EP5 MS.03.01.01

⁸ EP7 MS.03.01.01

⁹ MS.08.01.01; MS.08.01.03

¹⁰ EP1 & EP2 MS.01.01.01

¹¹ MS.10.01.01

2.3 Bylaws Purpose

The purpose of these Bylaws is:

2.3.1 To establish a framework within which the fundamental objectives of UK HealthCare to provide comprehensive medical clinical services, including diagnostic, curative and palliative medical care, preventive medical care, care and rehabilitation of the chronically ill and disabled, dental care, and facilities for education and research for those engaged in activities related to comprehensive medical clinical services may be effectuated through orderly governance and through the performance of credentialing;

2.3.2 To define the organizational structure of the Medical Staff, the rules for its self-governance and its responsibilities in the oversight of care, treatment and services;¹²

2.3.3 To establish a collaborative relationship among the Medical Staff, the MEC, Administration and the University Health Care Committee;

2.3.4 To promote communication and interaction between clinical services, and functions throughout UK HealthCare to improve operations and clinical outcomes;

2.3.5 To facilitate the formulation of long-range and short-range health planning goals;

2.3.6 To provide a method of continuous self-evaluation of the medical clinical service through the delineation of clinical privileges and review of clinical activities to improve performance and clinical outcomes;

2.3.7 To develop and maintain high standards in medical education programs and provide for continued medical education of Practitioners; and

2.3.8 To provide a means whereby issues and conflicts concerning the Medical Staff and UK HealthCare may be discussed, managed, and resolved.

ARTICLE 3

MEDICAL STAFF MEMBERSHIP

3.1 Nature of Membership

Appointment to the Medical Staff is a privilege. Membership and the exercise of clinical privileges shall be extended only to Practitioners who continuously meet the requirements of these Bylaws. No person shall admit or provide clinical services to patients of either Hospital unless he/she is appointed to the Medical Staff or has been granted clinical privileges at the appropriate Hospital. Appointment to the Medical Staff and delineation of clinical privileges shall confer on the appointee only such clinical privileges as are granted by the University Health Care Committee. For purposes of these Bylaws, "membership in" has the same meaning as "appointment to" the Medical Staff, however, neither is synonymous with the grant of clinical privileges. Similarly, the granting of clinical privileges does not automatically confer Medical Staff membership or appointment. As provided in these Bylaws, a person may be

¹² MS.01.01.01

granted clinical privileges without Medical Staff membership or appointment.

3.2 Qualifications for Membership¹³

3.2.1 To be qualified for appointment to the Medical Staff, a Practitioner must:

(a) Have documented current experience, education, background, training, clinical and professional judgment, demonstrated competence, and physical and mental health status (with or without reasonable accommodation) to demonstrate that patients treated by him/her will receive care of the generally recognized professional level of quality and efficiency established by UK HealthCare.¹⁴

(b) Have documented current licensure in good standing and without restriction imposed by the Kentucky Board of Medical Licensure or the Kentucky Board of Dentistry.

(c) Be determined, on the basis of documented references, to adhere strictly to the ethics of his/her profession, to work cooperatively and collegially with others in a professional manner, and to be willing to participate in and properly discharge Medical Staff responsibilities.

(d) Be a graduate of a medical or dental institution accredited by (i) the Liaison Committee on Medical Education, (ii) the American Osteopathic Association Commission on Osteopathic College Accreditation, (iii) the American Dental Association or, if a foreign medical graduate, be certified by the Educational Commission for Foreign Medical Graduates.

(e) If a physician, meet one of the following criteria:

(i) Have completed a residency program accredited by the ACGME or the American Osteopathic Association in the specialty area for which clinical privileges are sought, and either be board certified in that specialty by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or become board certified within the timeframe required by the applicable board, and maintain such certification, including any required periodic recertification. In exceptional cases, a physician who meets these training requirements but is not board certified may be granted a written exemption by the MEC upon recommendation of the department Chair; or

(ii) If serving as a full-time or part-time faculty member of the University of Kentucky, have documented experience equivalent to completion of residency or fellowship and board certification, and have received a written exemption from the board certification requirement from the MEC upon recommendation of the faculty member's department Chair.

(f) If a dentist, the individual must meet one of the following criteria:

¹³ EP1 MS.07.01.01

¹⁴ EP2 MS.07.01.01

(i) Practice in a specialty area for which board certification is not available; or

(ii) Practice in a specialty area for which board certification is available, and either be board certified by the applicable specialty board, or become board certified within the timeframe required following completion of residency or post-dental training, and maintain such certification, including any required periodic recertification. In lieu of board certification, the individual may be granted an exemption by the MEC upon recommendation of the faculty member's Chair or the Dean of the College of Dentistry, with a written request submitted to the President of the Medical Staff. Additionally, individuals employed by the University of Kentucky prior to December 2026 may be exempt from the board certification requirement upon written request by the faculty member's Chair or the Dean of the College of Dentistry, submitted to the President of the Medical Staff.

(g) Maintain continuous and effective professional liability insurance coverage with an insurance company licensed and qualified to do business in Kentucky with no gaps in coverage and limits no less than \$1 million per occurrence and \$3 million annual aggregate or such other higher limits as may be required by the UK HealthCare Risk Management Committee or maintain continuous coverage under the University of Kentucky Self-Insured Professional Liability Program.

3.2.2 Unless otherwise provided in these Bylaws, Practitioners who wish to be members of the Medical Staff or exercise clinical privileges at either Hospital must maintain their residences and offices close enough to the applicable Hospital to provide continuous care to their patients. Locations which are "close enough" to the Hospital to satisfy this requirement may vary depending upon the Practitioner's specialty, Medical Staff category, and clinical privileges granted.

3.2.3 No person shall be automatically entitled to Medical Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice, is a member of any professional organization, is certified by any board, or had or has medical staff membership or clinical privileges in any hospital or any other healthcare facility or provider.

3.2.4 Neither Medical Staff membership nor the granting of clinical privileges shall be denied on the basis of race, color, ethnic origin, national origin, creed, religion, political belief, gender, sexual orientation, marital status, age or disability, service in the armed forces or any other reason prohibited by law.¹⁵

3.2.5 No Practitioner shall be appointed to the Medical Staff or granted clinical privileges if the Hospital where such clinical privileges will be exercised is unable to provide adequate facilities and supportive services for such Practitioner and his/her patients.

3.2.6 No Practitioner shall be eligible or qualified for Medical Staff membership who:

(a) is listed as an "excluded provider" on either the OIG Sanction Report or the GSA List, or

(b) does not participate in the federally funded health care programs,

¹⁵ EP3 MS.06.01.07; EP4 MS.07.01.01

including Medicare and Medicaid, or

(c) has been convicted or has pled guilty or nolo contendere to any felony within the immediate past 10 years or to any felony or misdemeanor at any time involving (i) the practice of such Practitioner's profession or the delivery of health care services, (ii) controlled substances, (iii) illegal drugs, (iv) Medicare, Medicaid, or insurance fraud or abuse, (v) violence against another, or (vi) moral turpitude.

3.3 Basic Responsibilities of Medical Staff Membership

Except for the Honorary or Emeritus with Clinical Privileges members of medical staff, the ongoing responsibilities of each member of the Medical Staff shall include, without limitation:

3.3.1 Continuously providing patients with quality care in a reasonably efficient manner that meets generally recognized professional standards, including the Behavioral Standards in Patient Care;

3.3.2 Completing or causing to be completed and documenting a medical history and physical examination the content of which shall be determined by UK HealthCare policy, for each patient assigned to the care of the Medical Staff member no more than 30 calendar days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services which medical history and physical examination is completed and documented by a Medical Staff member or other qualified and appropriately privileged licensed practitioner in accordance with State law and UK HealthCare policy;¹⁶

3.3.3 Completing or causing to be completed and documenting an updated examination the content of which shall be determined by UK HealthCare policy, of each patient assigned to the care of the Medical Staff member, including any changes in the patient's condition, within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 calendar days before admission or registration which updated examination of the patient, including any changes in the patient's condition, is completed and documented by a Medical Staff member or other qualified and appropriately privileged licensed practitioner in accordance with State law and UK HealthCare policy;¹⁷

3.3.4 Participating in emergency service and call coverage and consultation panels;

3.3.5 Seeking consultation, in accordance with generally accepted standards of patient care, in accordance with UK HealthCare policy, or when requested by a Chief Medical Officer or the President of the Medical Staff;

3.3.6 Preparing and completing in timely fashion in accordance with UK HealthCare policy, all medical records for the patients to whom the member provides care in a Hospital;

3.3.7 As the attending physician or dentist, informing his/her patients of

¹⁶ EP16 MS.01.01.01; 42 CFR 482.22; EP6 & EP8 MS.03.01.01

¹⁷ EP16 MS.01.01.01; 42 CFR 482.22; EP6 & EP8 MS.03.01.01

outcomes of care, including unanticipated outcomes;

3.3.8 Making timely and appropriate arrangements for coverage of patients;

3.3.9 Participating on, with, or in Hospital or multidisciplinary committees, teams, or programs dealing with the overall medical environment at the Hospitals including, without limitation, medical records, quality improvement, utilization review, practice guidelines, blood and blood component usage review, nursing services, drug usage and formularies, infection control, radiation safety, risk management, operative and invasive procedure review, safety, and patient care policies;

3.3.10 Participating in the UK HealthCare performance improvement activities to improve quality of care, treatment and services, and patient safety, including peer review activities;

3.3.11 Participating in the UK HealthCare risk management program, including without limitation reporting promptly to the UK HealthCare Risk Management Office all claims, potential claims, actions, demands, and within ten calendar days after entered or made, all final judgments, and settlements, involving professional liability claims or proceedings;

3.3.12 Participating in communicable disease prevention by complying with UK HealthCare communicable disease and immunization policies applicable to UK HealthCare employees;

3.3.13 Completing such reasonable responsibilities, assignments, and rotations required by virtue of Medical Staff membership, including committee assignments, proctoring of Practitioners, attendance requirements, and accreditation requirements;

3.3.14 Performing a sufficient number of procedures, managing a sufficient number of cases, and having sufficient Patient Encounters within the Practitioner's practice to permit the assessment of the Practitioner's current clinical competence for any clinical privileges, whether being requested or already granted;

3.3.15 Maintaining current professional competence through appropriate continuing education programs;

3.3.16 Abiding by the Governance Documents, as the same may be applicable to such member of the Medical Staff, and the Principles of Medical Ethics of the American Medical Association and the American Osteopathic Association or the Code of Ethics of the American Dental Association, as applicable;¹⁸

3.3.17 Maintaining confidentiality and the proper use and disclosure of "protected health information," as provided by HIPAA;

3.3.18 Desisting from improper inducements for patient referral or other unlawful or unethical behavior;

3.3.19 Informing the CMO Office, orally and in writing, immediately upon his/her knowledge and in any event immediately upon his/her receipt of notice, of any changes made to or formal action initiated that could result in a change or restriction of license, DEA

¹⁸ EP5 MS.01.01.01

registration, participation in any program or plan for the reimbursement of clinical services, professional liability insurance coverage, membership, employment status or clinical privileges at other health care institutions or affiliations, and the status and initiation of malpractice claims;

3.3.20 Informing the CMO Office, orally and in writing, immediately if: he/she is under investigation by, threatened with exclusion from, or excluded from or voluntarily or involuntarily terminates his/her participation in any health care program funded in whole or in part by the federal government, including Medicare or Medicaid; he/she receives notice of any proposed or actual sanctions against him/her in connection with participation any such health care program; or he/she ceases to meet any of the qualifications for membership on the Medical Staff as set out in Section 3.2, above;

3.3.21 Consenting to alcohol and drug testing or psychiatric or medical evaluation when requested by the Practitioner's Chair, a Chief Medical Officer, the Executive Chief Medical Officer, the President of the Medical Staff or a Chief Clinical Officer, which request and the basis for same shall be reported to such Chair, a Chief Medical Officer, the Executive Chief Medical Officer, the President of the Medical Staff and the Chief Clinical Officer;

3.3.22 Cooperating with UK HealthCare in matters involving its fiscal responsibility and policies, including those relating to payment or reimbursement of costs by governmental and third-party payers, and to participate in UK HealthCare peer review, utilization management, and quality improvement activities, including activities and assessments for improving organizational performance;

3.3.23 If a UK faculty member, supervising residents (post-graduate medical and dental trainees) as appropriate to their level of training, according to UK HealthCare policy relating to supervision of house staff;¹⁹

3.3.24 If a UK faculty member, aiding and participating in approved educational programs for medical students, interns, resident physicians, resident dentists, physicians and dentists, podiatrists, clinical psychologists, nurses, and other personnel; and

3.3.25 Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff, the MEC, or the University Health Care Committee.

3.4 Authority of the University Health Care Committee

Medical Staff appointments and clinical privileges shall be granted, modified, suspended, and revoked only by the University Health Care Committee, except as specifically and expressly provided in these Bylaws. In exercising such authority, the University Health Care Committee shall comply with the Bylaws, as well as the UK Governing Regulations, the UK Administrative Regulations, and the operating rules of such committee.

¹⁹ EP1 MS.04.01.01

ARTICLE 4

CATEGORIES OF THE MEDICAL STAFF

4.1 Categories²⁰

The Medical Staff shall be divided into categories denominated Active Faculty, Courtesy, Voluntary, Clinical Fellow, University Health, Honorary, and Emeritus.

4.2 Faculty Appointment²¹

Members of the Medical Staff in the Active Faculty, Clinical Fellow, and Voluntary categories must either currently hold or have an application in process and pending final action by the Board of Trustees for a faculty appointment in the UK College of Medicine, Dentistry or Public Health. If the applicant is not appointed to the faculty or his/her faculty appointment terminates for any reason, his/her Medical Staff appointment and clinical privileges automatically will terminate, without a hearing or appeal. Members of the Medical Staff in the University Health category must be employed by the University but are not appointed to the faculty of the University. Members of the Medical Staff in the Courtesy, Honorary, or Emeritus categories are not required to be appointed to the faculty of the University.

4.3 Organized Medical Staff²²

4.3.1 The following members of the Active Faculty categories shall be entitled to vote and shall therefore comprise the Organized Medical Staff:

- (a) Executive Chief Medical Officer and each Chief Medical Officer;
- (b) All Chairs;
- (c) Each medical director appointed by a Chief Medical Officer upon consultation with the appropriate Chair and approved by the Executive Chief Medical Officer, with funding provided through the CMO Office and an express allocation of effort for medical director duties;
- (d) Each service line, section and division chief;
- (e) Each elected officer of the Medical Staff;
- (f) Each University of Kentucky or UK HealthCare center director;
- (g) Each member of the MEC, the Peer Review Committee, and the Credentials Committee who is a member of the Medical Staff;
- (h) Each chair of the other Medical Staff standing committees identified in these Bylaws who is a member of the Medical Staff;
- (i) Each residency Program Director; and
- (j) The Chief Clinical Officer.

²⁰ EP12 MS.01.01.01

²¹ EP13 MS.01.01.01

²² EP17 MS.01.01.01

4.3.2 Members of the Organized Medical Staff are required to attend meetings of the Medical Staff as able and to participate actively in the responsibilities of the Organized Medical Staff.

4.4 Active Faculty²³

The Active Faculty category shall be comprised of physicians and dentists who are faculty members of the UK College of Medicine, Dentistry, or Public Health and have been endorsed by their respective Chair as having competence in their area of practice and being active in the teaching program of the University. Clinical privileges shall be delineated upon appointment and with each reappointment. Members of the Active Faculty staff may attend meetings of the Medical Staff, may hold office, and if appointed, shall serve on standing or ad hoc Medical Staff committees. Unless the Active Faculty member is a member of the Organized Medical Staff defined above, however, the member does not have the right to vote.

4.5 Courtesy²⁴

The Courtesy category shall be comprised of physicians and dentists who are not employed by the University of Kentucky and are not faculty members of the UK College of Medicine, Dentistry or Public Health but have been endorsed by their respective Chair as having competence in their area of practice. Such member shall be required to obtain and maintain Class I clinical privileges, as defined in Section 7.4, below, in his/her area of practice in accordance with Section 7.7., below. Courtesy members shall have fewer than 30 Patient Encounters during any consecutive four calendar quarters. However, Courtesy members shall have a sufficient number of Patient Encounters within the Practitioner's practice to permit ongoing professional practice evaluation of the Practitioner's current clinical competence for any clinical privileges. Courtesy members who have no Patient Encounters within any two-year term of appointment or reappointment to the Medical Staff shall be deemed to have resigned from the Medical Staff and their clinical privileges shall be automatically terminated. Courtesy members who have 30 or more Patient Encounters during any consecutive four calendar quarters may be required to provide emergency service and call coverage and participate on consultation panels. Clinical privileges shall be delineated upon appointment and with each reappointment. Members of the Courtesy staff may not hold office and may not vote at meetings of the Medical Staff, but they may attend Medical Staff meetings and serve as members but not as chairs on standing or ad hoc Medical Staff committees. Courtesy staff members may, when necessary in the judgment of the Chair, be assigned the responsibility to care for unassigned patients, including emergency clinical service, consultations, and appropriate office follow-up.

4.6 University Health²⁵

The University Health category shall be comprised of physicians and dentists who are employed by the University of Kentucky but who are not faculty members of the UK College of Medicine, Dentistry or Public Health, to provide health care clinical services to UK students

²³ EP15 MS.01.01.01

²⁴ EP15 MS.01.01.01

²⁵ EP15 MS.01.01.01

and employee health services to UK employees and have been endorsed by the Chief Clinical Officer as having competence in their area of practice. Clinical privileges shall be delineated upon appointment and with each reappointment; however, clinical privileges shall not exceed Class II, as defined in Section 7.4, below. Members of the University Health category staff may not hold office and may not vote at meetings of the Medical Staff, but they may attend Medical Staff meetings and may serve as members but not as chairs on standing or ad hoc Medical Staff committees.

4.7 Voluntary²⁶

The Voluntary category shall be comprised of Practitioners, who are volunteer faculty of the UK College of Medicine, Dentistry or Public Health and have been endorsed by their respective Chair as having competence in their area of practice and contributing to the teaching programs of the University. Clinical privileges shall be delineated upon appointment and with each reappointment and shall be consistent with the Voluntary member's teaching contribution. Members of the Voluntary category may not hold office and may not vote at meetings of the Medical Staff, but they may attend Medical Staff meetings and serve as members but not as chairs on standing or ad hoc Medical Staff committees. Community physicians appointed to the faculty, on a part-time basis or as volunteers, should be effective teachers, serve as role models for students, and provide insight into contemporary methods of providing patient care.

4.8 Clinical Fellow²⁷

The Clinical Fellow category shall be comprised of Practitioners who are employed full-time by the University of Kentucky, have completed all residency requirements for specialty boards and where applicable subspecialty boards and have been endorsed by their respective Chair as having competence in their area of practice and being engaged in specifically defined, non-ACGME accredited, post-residency programs of research development, investigation, training, and/or clinical fellow patient care programs. Clinical privileges shall be delineated on appointment and with each reappointment. Members of the Clinical Fellow category may not hold office and may not vote at meetings of the Medical Staff, but they may attend Medical Staff meetings, serve as members but not as chairs on standing and ad hoc Medical Staff committees and, as a member of the Medical Staff, may admit and manage patients in any Hospital and UK HealthCare clinics consistent with delineated clinical privileges.

4.9 Honorary

The Honorary category shall be comprised of Practitioners who were previously members of the Active staff and are no longer actively practicing in either Hospital or who are of outstanding reputation, not necessarily residing in the community. Honorary members shall not be eligible to admit patients, vote, hold office, or serve on standing or ad hoc Medical Staff committees. They shall be recommended by the MEC, subject to the approval of the University Health Care Committee. No further appointment to the Medical Staff is required unless a change in status is requested. They may attend Medical Staff meetings.

²⁶ EP15 MS.01.01.01

²⁷ EP15 MS.01.01.01

4.10 Emeritus with Clinical Privileges

The Emeritus category is available to Practitioners who have substantially retired from clinical practice but may occasionally provide direct patient care at the request of their department. These physicians or dentists must have previously served as Active Medical Staff members in good standing for at least five (5) years. They may be granted limited clinical privileges based on departmental need and institutional requirements. Emeritus with Clinical Privileges Staff are not required to take call or attend Medical Staff meetings but must maintain current licensure and board certification if practicing. They are not entitled to fair hearing rights unless they hold clinical privileges and an adverse action is proposed against those privileges.

ARTICLE 5

HEALTH PROFESSIONAL STAFF

5.1 Membership and Identification

The Health Professional Staff include faculty members of the University of Kentucky, staff employees of the University of Kentucky, or of University contractors and selected volunteers, who are appointed by the University Health Care Committee. Members of the Health Professional Staff shall be identified as Health Professional Staff of a particular clinical service. Although members of the Health Professional Staff shall not be considered members of the Medical Staff, they nevertheless shall be bound by these Bylaws. With respect to the actions described in Section 9.2.1, below, taken based on clinical deficiencies, they shall be entitled to the procedures set forth in the Fair Hearing Plan.

With respect to all other corrective actions, they shall be entitled to the grievance and appeal procedures set forth in the UK Administrative Regulations, the University Senate Rules and Regulations and the UK Human Resources Policies and Procedures, the policies and procedures of their employer, as may be applicable, and they shall not be entitled to the procedures set forth in the Fair Hearing Plan

5.2 Clinical Privileges

Members of the Health Professional Staff shall have clinical privileges delineated in accordance with the scope of their licensure, as permitted by statute and as granted upon appointment and reappointment. Clinical privileges for individuals involved with the management of patients will be under the supervision of an Active Medical Staff member consistent with the requirements of applicable Kentucky law and will be strictly limited to the performance of specialized clinical services within the field of the member's competence. The clinical privileges will be specifically designated by individual by the University Health Care Committee and will be noted in the individual's credentials file.

5.3 Application Process²⁸

All applications for appointment to the Health Professional Staff shall be submitted on the application form(s) mandated by the Commonwealth of Kentucky. Such forms shall be

²⁸ EP26 MS.01.01.01

completed and signed by each applicant who, as a condition to applying, shall agree to be bound by the Governance Documents and the appropriate ethical standards governing the licensed practitioner's practice. The procedures, inquiries, and commitments set forth in these Bylaws for membership on the Medical Staff shall likewise apply to membership on the Health Professional Staff, and submission of a completed application for membership on the Health Professional Staff shall constitute acknowledgment by the applicant that the Medical Staff procedures, inquiries, and commitments are applicable.

5.4 Conditions and Term of Appointment

5.4.1 The same conditions set forth in these Bylaws for members of the Medical Staff shall likewise apply to applications and members of the Health Professional Staff, to the extent applicable.

5.4.2 Appointment to the Health Professional Staff shall confer on the appointee only such clinical privileges as have been set forth in the appointment.

5.4.3 The term of appointment and each reappointment shall be for three years.

5.5 Medical History and Physical Examination²⁹

Physician assistants and advanced practice registered nurses who are members of the Health Professional Staff may, to the extent permitted by Kentucky and federal law and consistent with clinical privileges granted and UK HealthCare policy, perform and document medical histories and physical examinations and updates thereto required under Sections 3.3.2 and 3.3.3, above.

5.6 Medical Screening

Physician assistants and advanced practice registered nurses who are members of the Health Professional Staff may, to the extent permitted by Kentucky and federal law and consistent with clinical privileges granted and UK HealthCare policy, perform and document medical screening examinations required under 42 CFR 489.24(a)(1)(i), under the direction of the Chair of Emergency Medicine and subject to supervision of an Active Medical Staff member.

ARTICLE 6

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT³⁰

6.1 General³¹

These Bylaws provide the basic procedural steps for appointment and reappointment and granting of clinical privileges. Associated details for this procedure may be set forth in policies adopted by the MEC or by the Credentials Committee from time to time with prior notice to the Organized Medical Staff and approved by the University Health Care Committee.

²⁹ EP16 MS.01.01.01; EP9 MS.03.01.01

³⁰ EP14 & EP 27 MS.01.01.01; EP1, EP3 & EP4 MS.06.01.03; EP4 & EP5 MS.06.01.05; EP1 MS.06.01.07; EP4 MS07.01.01

³¹ EP2 MS.06.01.07

6.2 Appointment

6.2.1 Application for Membership³²

(a) Each application for Medical Staff appointment and/or clinical privileges shall be in writing, submitted on the applicable Commonwealth of Kentucky mandated applications(s) or form(s), and signed by the applicant. Each applicant shall provide the following information:

(i) Detailed information concerning the applicant's qualifications, including information on his/her medical or other professional degree and any specialty board certification, post-graduate training, past and present licenses to practice, and DEA registration;³³

(ii) The Medical Staff category and clinical privileges requested;

(iii) The names of at least three Practitioners who are not related to the applicant, at least two of whom shall be a peer of the applicant, and with respect to a non-UK faculty applicant, at least one of whom shall not be a partner or associate in the applicant's practice, who will provide references as to the applicant's current medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

(iv) Information as to prior, pending or currently threatened investigations or other challenges to any licensure, certification or registration (including by any state or the Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification, or registration;

(v) Information as to voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, denial or loss of clinical privileges at a Hospital or another hospital or health care facility;

(vi) Information about applicant's past (at least ten years) and present professional liability insurance coverage (carrier, limits, coverage dates) and a consent to the release of information from past and present liability carriers;

(vii) Information as to at least the past ten years malpractice judgments, suits, cases, actions or proceedings against him/her, either pending, dismissed, settled, filed, or threatened, including any final judgments and settlements;

(viii) Information as to current physical and mental health status as it relates to the applicant's ability, with or without reasonable accommodation, to perform clinical privileges requested;

(ix) Information as to any sanctions imposed under the Medicare, Medicaid or other federally funded healthcare programs;

³² EP2, EP3 & EP9 MS.06.01.05; EP5 MS.06.01.07

³³ EP1 MS.06.01.05

- (x) Proof of authorization to work in the United States based on citizenship or immigration status;
- (xi) Any pending application for medical staff membership or clinical privileges at another health care facility, program, or managed care plan;
- (xii) Any criminal convictions, guilty pleas and *nolo contendere* pleas, involving any felony or any misdemeanor, excluding minor traffic violations but including driving under the influence of alcohol or drugs, in any jurisdiction;
- (xiii) A current picture hospital identification card or a valid picture identification card issued by a federal or state agency such as a passport or driver's license;³⁴
- (xiv) Data from ongoing professional practice evaluation by an organization that currently privileges the applicant if available, including any relevant Practitioner-specific data as compared to aggregate data and morbidity and mortality data;³⁵ and
- (xv) Such other information as may be required in order to evaluate the applicant with respect to competency in patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

(b) Certain Statements. The applicant shall affirm that:

- (i) The applicant has access to and understands and agrees to abide by the provisions of the Governing Documents, including the Bylaws and the Behavioral Standards in Patient Care, including specifically those bylaws and standards relating to privileges and immunities;
- (ii) The applicant agrees to provide continuous care to patients and to fulfill each of the basic responsibilities of Medical Staff members set forth in Section 3.3, above;
- (iii) The applicant releases from any and all liability those persons to whom such privileges and immunities provisions of these Bylaws are intended to benefit;
- (iv) The applicant has no health problems that could affect his or her ability to perform the clinical privileges requested;³⁶
- (v) The applicant agrees that when an adverse ruling is made concerning his/her appointment, Medical Staff status, or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings; and

³⁴ EP5 MS.06.01.03

³⁵ EP3 MS.08.01.03

³⁶ EP6 MS.06.01.05

(vi) The applicant will have and continuously maintain professional liability insurance covering acts and occurrences involving professional activities during the period of Medical Staff membership and while clinical privileges are granted, as approved by the University Health Care Committee, with coverage for all clinical privileges granted.

(c) Obligations. By applying for Medical Staff appointment and/or clinical privileges, each applicant:

(i) Agrees to appear for interviews regarding his/her application;

(ii) Authorizes UK HealthCare to consult with Practitioners at other hospitals and healthcare facilities with which the applicant has been associated, and with others who may have information bearing on his/her competence, character and ethical qualifications;

(iii) Consents to UK HealthCare's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as his/her character, moral and ethical qualifications for Medical Staff membership;

(iv) Consents to criminal background searches;

(v) Agrees to comply with UK HealthCare health screening, including drug and alcohol tests;

(vi) Consents to UK HealthCare's obtaining information from peer review and professional review organizations, boards, and committees, and authorizes the release of such information to UK HealthCare, and releases from liability all persons specified in these Bylaws to the fullest extent permitted by law; and

(vii) Agrees that UK HealthCare may obtain an evaluation of the applicant by a consultant selected by the CMO Office if any of a Chief Medical Officer, the Executive Chief Medical Officer, the MEC, the Peer Review Committee, the Chief Clinical Officer, or the University Health Care Committee considers it appropriate.

6.2.2 Failure by the applicant to provide truthful, accurate and complete information shall in itself be grounds for denial, or revocation of Medical Staff membership and appointment, reappointment and clinical privileges.

6.2.3 Burden on Applicant. In all matters pertaining to the applicant's application for initial appointment and clinical privileges, and for reappointment, renewal, and/or updating of clinical privileges, and validation of supporting information, the burden is on that of the applicant. Processing of the application cannot begin until all required information is on file and validated. The applicant shall have the responsibility of producing a fully complete application and such other information as may be reasonably requested for a proper evaluation of his/her experience, background, training, demonstrated ability, previous performance, current competence, physical and mental health status and of resolving any doubts about such matters. The applicant shall have a continuing responsibility to provide updated information to the Medical Staff Affairs Office, if any information in the application changes between the date it is submitted and the date on which final action and a final decision on the application are

taken or made. If an application is incomplete or information is unclear, a request will be made for additional or clarifying information which the applicant will provide or cause to be provided. The reason for the additional information will be communicated to the applicant.

6.2.4 Application. For all applicants, the applicant shall submit his/her application to the Medical Staff Affairs Office or to the Third-Party Service.

6.2.5 Department Review for Faculty and UK Employees.³⁷ Upon receipt of an application from a faculty and UK employee applicant, the Chair shall verify that the application form is completely filled out, that all required attachments are included and that the application is signed. Upon such verification, the Chair will submit the application to each division chief and other Chair for any division or other department in which clinical privileges are sought and request documented opinions and recommendations as to Medical Staff appointment or clinical privileges from each. Each Chair and division chief may conduct a personal interview of the applicant and may request additional information from the applicant, if he/she deems it necessary, in which event the applicant shall promptly furnish the requested information. Thereafter, each Chair and division chief shall make recommendations as to Medical Staff appointment and, if appointment is recommended, Medical Staff category and clinical service, clinical privileges to be granted, and any special conditions to the appointment. Recommendations will be based on criteria directly related to the quality of health care, treatment and services including the areas of competency described in Section 6.2.1(a)(iii), above. The reasons for an adverse recommendation shall be stated. Upon obtaining such opinions and recommendations, the Chair shall submit the application to the Medical Staff Affairs Office together with all such opinions and recommendations, including that of the Chair.

6.2.6 Credential Verification.³⁸ Upon receipt of an application, the Medical Staff Affairs Office or the Third-Party Service shall arrange to verify (i) references, (ii) licensure, including licensure in all states, (iii) DEA, (iv) malpractice insurance, (v) relevant training or experience, (vi) current competence, (vii) ability to perform the privileges requested, (viii) no current or previously successful challenge to licensure or registration, (ix) no subjection to involuntary termination of medical staff membership at another organization, (x) no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges, and (xi) other qualification evidence submitted. Such verification shall include obtaining information reported pursuant to the HCQIA, a search of the OIG Sanction Report, the GSA List and other Federal and State reports of sanctions, including State Medical Boards and obtaining a criminal background check to ensure the individual has not been officially sanctioned and is not ineligible for appointment to the Medical Staff. The Medical Staff Affairs Office or Third-Party Service shall consult primary sources of information about the Practitioner's credentials, where feasible. The Medical Staff Affairs Office or Third-Party Service shall promptly notify the applicant of any problems in obtaining required information. It shall be the responsibility of the applicant to ensure that all required information is submitted directly to the Medical Staff Affairs Office or Third-Party Service by all reference sources.

³⁷ EP2 MS.06.01.03; EP6 MS.06.01.07

³⁸ EP6 MS.06.01.03; EP7 MS.06.01.05; EP3 MS.06.01.13

6.2.7 Department Review for Non-Faculty and Non-UK Employees. After verification is accomplished and the application is fully complete for each non-faculty and non- UK employee applicant, the Medical Staff Affairs Office shall transmit a copy of the application and supporting materials to the Chair of each clinical service in which the applicant seeks clinical privileges, including the appropriate Chair at Chandler Hospital, and request documented opinions and recommendations as to Medical Staff appointment or clinical privileges. Each Chair may conduct a personal interview of the applicant and may request additional information from the applicant, if he/she deems it necessary, in which event the applicant shall promptly furnish the requested information. Thereafter, each Chair shall make recommendations as to Medical Staff appointment and, if appointment is recommended, Medical Staff category and clinical service, clinical privileges to be granted, and any special conditions to the appointment. Recommendations will be based on criteria directly related to the quality of health care, treatment and services including the areas of competency described in Section 6.2.1(a)(iii), above. The reasons for an adverse recommendation shall be stated. The report shall then be transmitted to the Medical Staff Affairs Office.

6.2.8 Meeting. The Medical Staff Affairs Office shall provide the Chair with a report of all adverse findings, opinions or recommendations received, if any, with respect to the applicant. Upon request of the Medical Staff Affairs Office or the Chair, a meeting among the applicant, the Chair, and such other persons as may be designated by the Medical Staff Affairs Office shall be held to discuss the application.

6.2.9 Application Package. An application shall be considered complete only after all required documents and information, including the reports, opinions and recommendations of the Chair (and Chief of the Division, if applicable), have been collected, received, and verified. The Medical Staff Affairs Office, upon completion of the application, shall submit the application, supporting materials, the reports, opinions and recommendations of the Chair (and Chief of the Division, if applicable), and such other available information as may be relevant to the applicant's qualifications (the "application package") to the Credentials Committee.

6.2.10 Credentials Committee Action.³⁹

(a) As promptly as practicable after the Credentials Committee receives the application package from the Medical Staff Affairs Office, the Credentials Committee shall:

(i) Review the clinical performance information that is available and shall determine whether such information is sufficient to make a decision regarding the application; or

(ii) If the information is insufficient, the Credentials Committee shall either request additional information, make a recommendation to grant provisional clinical privileges for a period of time during which clinical performance information will be collected for consideration or recommend that the requested clinical privileges be limited or denied.

³⁹ EP10 MS.06.01.05; EP1 & EP2 MS.06.01.01

(b) The Credentials Committee may refer the application package to any Privileging Subcommittee(s) in which case the Privileging Subcommittee(s) shall perform the responsibilities described in Sections 6.2 and shall promptly transmit a written report, including its recommendation to the Credentials Committee as to clinical privileges to be granted and any special conditions to such clinical privileges based on an objective, evidence-based process. Recommendations will be based on criteria directly related to the quality of health care, treatment and services including the areas of competency described in Section 6.2.1(a)(iii), above. The reasons for an adverse recommendation shall be stated. The Credentials Committee, upon consultation with the Chief Clinical Officer and the Chief Operating Officer, shall determine whether the resources necessary to support each requested privilege are currently available or will be available within a specified time frame before recommending that the requested privilege be granted. The Credentials Committee shall transmit a written report, including its recommendation to the Chief Clinical Officer and the MEC that the applicant be appointed to the Medical Staff or be rejected for membership, or that the application be deferred for further consideration. If appointment is recommended, the Credentials Committee shall recommend the Medical Staff category and clinical service, clinical privileges to be granted, and any special conditions to the appointment and clinical privileges. If appointment and clinical privileges are recommended, the Chief Clinical Officer may, with the recommendation of the President of the Medical Staff, grant temporary clinical privileges as set forth in Section 7.7., below.

6.2.11 Medical Staff Executive Committee Action. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the MEC shall determine whether to recommend to the University Health Care Committee that the Practitioner be provisionally appointed to the Medical Staff or be rejected for Medical Staff membership, or the application be deferred for further consideration. Recommendations will be based on criteria directly related to the quality of health care, treatment and services including the areas of competency described in Section 6.2.1(a)(iii), above. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

(a) When the recommendation of the MEC is to defer the application for further consideration, it must be followed up within 30 calendar days with a subsequent recommendation for provisional appointment with specified clinical privileges, for rejection for Medical Staff membership or for additional deferment, subject to the requirements for timely processing of applications described in Section 6.2.13, below.

(b) When the recommendation of the MEC is favorable to the applicant, the President of the Medical Staff shall promptly forward it, together with all supporting documentation, to the University Health Care Committee.

(c) When the recommendation of the MEC is adverse to the applicant in respect to appointment or clinical privileges, the President of the Medical Staff shall promptly notify the applicant in accordance with Section 9.3, below. Except with respect to recommendations described in Section 9.2.2, below, no such adverse recommendation need be forwarded to the University Health Care Committee until after the applicant has exercised, or has been deemed to have waived, the right to a hearing as provided for in the Fair Hearing Plan. If the applicant exercises the right to a hearing as provided for in the Fair Hearing Plan, the

matter shall be forwarded to the University Health Care Committee as provided in the Fair Hearing Plan.

6.2.12 University Health Care Committee⁴⁰

(a) At its next regular meeting after receipt of a favorable recommendation of the MEC, the University Health Care Committee shall act on the matter. Decisions will be based on criteria directly related to the quality of health care, treatment and services including the areas of competency described in Section 6.2.1(a)(iii), above. If the University Health Care Committee's decision is adverse to the applicant in respect to either appointment or clinical privileges, the President of the Medical Staff shall promptly notify the applicant of such adverse decision in accordance with Section 9.3, below, and except with respect to decisions described in Section 9.2.2, below, such adverse decision shall be held in abeyance until the applicant has exercised, or has been deemed to have waived, the applicant's rights under the Fair Hearing Plan, and the University Health Care Committee renders its final decision as provided in the Fair Hearing Plan either to appoint the applicant provisionally to the Medical Staff, or to reject the applicant for Medical Staff membership. The fact that the adverse decision is held in abeyance shall not be construed to confer clinical privileges where none exist. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

(b) Whenever the University Health Care Committee's decision will be contrary to the recommendation of the MEC, the University Health Care Committee shall submit the matter to the conflict management committee as described in UK HealthCare policy for review and recommendation and shall consider such recommendation before making its decision final.

(c) When the University Health Care Committee's decision is final, it shall send notice of such decision through the President of the Medical Staff, to the MEC, to the Chair, and to the applicant.⁴¹

(d) Privileges are granted for a period not to exceed three years.⁴²

6.2.13 Timely Processing of Application.⁴³ Application for Medical Staff appointment shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. The Credentials Committee shall take action within 180 calendar days from the date the application is deemed complete as provided in Section 6.2.9, above, unless *bona fide* questions exist regarding the applicant's education, qualification, current competency or ability to exercise clinical privileges and responsibilities under these Bylaws. In such case, additional time up to 90 calendar days may be taken to act on the application, after which time the application shall lapse and expire with no right to the

⁴⁰ EP8 MS.06.01.07; EP2 MS.06.01.09

⁴¹ EP1, EP3 & EP4 MS.06.01.09

⁴² EP9 MS.06.01.07

⁴³ EP11 MS.06.01.05; EP4 MS.06.01.07

procedures set forth in the Fair Hearing Plan.

6.2.14 Request that Application be Held in Abeyance. At any time in the application process prior to a recommendation by the MEC to the University Health Care Committee for final action, an applicant may request that his/her application be held in abeyance for a period up to, but no greater than 180 calendar days, after which time the application, unless the applicant has requested in writing that the process proceed, shall lapse and expire with no right to the procedures set forth in the Fair Hearing Plan. The applicant shall be required to submit a new application after such expiration to be considered for appointment. The burden shall be on the applicant to update immediately any information contained in the application.

6.2.15 Reapplication. An applicant who has received an adverse decision regarding appointment and/or clinical privileges shall not again be considered for at least two years after final notice of the decision is sent. Any such application shall be processed as an initial application.

6.3 Lapse of Application

If an applicant for Medical Staff appointment, a Medical Staff member who requests a modification of clinical privileges or clinical service assignment or a Medical Staff member who reapplies for Medical Staff appointment fails:

- (a) to furnish the information necessary to evaluate the request in a timely fashion,
- (b) to appear at interviews,
- (c) to obtain or submit required references or other documents, or otherwise complete the application process,
- (d) to meet threshold criteria, which do not take into account the applicant's specific individual professional competence or conduct, such as obtaining and maintaining a faculty appointment, satisfying the requirements set forth in Section 3.2, above, or performing a specific number of clinical or surgical procedures before consideration of the application can be given, then the application shall automatically lapse, and the applicant or Medical Staff member shall not have the procedural rights under the Fair Hearing Plan.

6.4 Provisional Status

Upon the recommendation by the MEC, and after approval of an applicant's application by the University Health Care Committee (which shall not be bound by the MEC's recommendation), an applicant shall be assigned to a clinical service and given a provisional appointment for a period of six months or the remainder of the first credentialing year for such clinical service, whichever is greater. Provisional status may be extended by the Chair or the MEC for up to two additional terms of six months for good cause. Provisional members shall have all the privileges and duties of full Medical Staff members in their category, except that they shall not be eligible to hold office or vote unless expressly permitted to do so by the University Health Care Committee.

6.4.1 Each Provisional member shall undergo a period of focused professional practice evaluation by designated monitors or proctors in accordance with Section 7.5, below.

The period shall be to evaluate the member's (a) proficiency in the exercise of clinical privileges initially granted and (b) overall eligibility for continued Medical Staff membership and advancement within Medical Staff categories. The evaluation shall be conducted by the clinical service under the direction of the Chair unless the privilege in question is new to the service in which case monitoring by an external source may be required. The results of the evaluation shall be communicated by the Chair or President of the Medical Staff to the MEC and the Peer Review Committee.⁴⁴

6.4.2 A decision to extend the period of Provisional membership or provisional clinical privileges by the Chair or MEC shall not be deemed to be a Professional Review Action that adversely affects the clinical privileges of the Provisional member and shall not entitle him/her to the procedures afforded by the Fair Hearing Plan. The Provisional member may, however, request further consideration of the MEC. If the decision of the MEC is adverse following further consideration, the Provisional member shall be entitled to the procedural rights provided in the Fair Hearing Plan.

6.4.3 Provisional members shall be eligible for advancement to membership on the Active or other Medical Staff category, but their status shall not be as full members of the Medical Staff until such advancement occurs. After completion of the provisional period, either the Provisional member shall be advanced to Active, Courtesy, Voluntary, Clinical Fellow, or University Health, in which case his/her clinical privileges shall no longer be provisional in nature, or his/her appointment and clinical privileges shall be terminated. The Chair shall recommend advancement after a review of the Provisional member's activities, if in the judgment of the Chair, the Provisional member is proficient in the clinical privileges requested and is eligible overall for continued Medical Staff membership and advancement. The Chair may recommend advancement of the Provisional member with a written notice to the Medical Staff Affairs Office, who will submit the information to the MEC and University Health Care Committee.

6.5 Reappointments

The Medical Staff Affairs Office or Third-Party Service shall, prior to the expiration date of the present Medical Staff appointment of each Medical Staff member, provide such Medical Staff member with a reappointment application packet for use in considering reappointment. The reappointment application packet shall include the applicable Commonwealth of Kentucky mandated application(s) or form(s). Each Medical Staff member who desires reappointment shall send his/her reappointment packet to the Chair or the Third- Party Service in the same manner as a new application is submitted. Failure to return the completed packet after a second written notice shall result in automatic termination of membership at the expiration of the member's current term.

6.5.1 Information

(a) The reappointment form shall be supplemental to the original application for appointment or the most recent application for reappointment, and the applicant shall supply any information about the applicant that is additional to or different from that

⁴⁴ EP1 MS.08.01.01

furnished on the original application form or that is furnished on his/her most recent reappointment application. All reappointment application forms shall contain the acknowledgments, authorizations, and releases set forth in Section 6.2, above. Any request for a change in clinical privileges shall be included by the applicant on the reappointment form.

(b) In addition, documentation of current Kentucky license, current federal narcotics registration, information regarding continuing education activities in which the applicant has participated since the last application (on request), and the name of one peer reference in the same professional discipline who can attest to the applicant's medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism, and ability to perform the clinical privileges requested shall accompany the reappointment application.⁴⁵

(c) Process for Consideration of Reappointment. Applications for reappointment shall be processed in accordance with the process described in Sections 6.2.4 through 6.2.15, above. Unless limited to a shorter period, reappointments shall be for a period of three years.

6.6 Other

6.6.1 Modifications of Category, Assignment, Clinical Privileges⁴⁶

(a) A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category, clinical service assignment consistent with clinical privileges granted or requested, or clinical privileges by submitting a request in writing to a Chief Medical Officer. Such request shall be processed in substantially the same manner as requests for appointment or clinical privileges.

(b) If new or additional clinical privileges are granted, they shall be considered provisional in nature, as in the case of initial clinical privileges granted.

6.6.2 Assistance. The University Health Care Committee, the MEC, the Credentials Committee or the CMO Office may:

(a) Obtain the assistance of independent consultants or others;

(b) Consider the results of quality and performance improvement activities of other hospitals or healthcare institutions with respect to the applicant;

(c) Request or require the applicant to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

(d) Request that specific patient records or categories of records of patients treated by the applicant be submitted for review, subject to appropriate protection of patient confidentiality; and

⁴⁵ EP2, EP3 & EP4 MS.07.01.03

⁴⁶ EP12 MS.06.01.05

(e) Require detailed statements, data, and information concerning matters that may affect the applicant's qualifications, professional competence or conduct, including information concerning threatened or pending legal or administrative proceedings.

6.6.3 License Verification. In addition to verification of credentials upon application for appointment and reappointment, the Medical Staff Affairs Office or the Third-Party Service shall verify the timely renewal of licensure, DEA registration and malpractice insurance upon expiration.⁴⁷

ARTICLE 7

CLINICAL PRIVILEGES⁴⁸

7.1 Exercise of Clinical Privileges⁴⁹

Clinical privileges must be within the scope of any license, certificate, or other legal credential authorizing practice in Kentucky and consistent with any restrictions thereon and shall be subject to the rules and regulations of the clinical service and the authority of the Chair and the Medical Staff. Each licensed practitioner shall be assigned to the primary clinical service in which clinical privileges are granted. If a Practitioner receives a joint appointment and wishes to exercise clinical privileges in a clinical service other than the Practitioner's primary clinical service, the Practitioner shall apply for and, if granted, receive clinical privileges in each clinical service in which the Practitioner is jointly appointed.

7.2 Admitting Clinical Privileges

Only Medical Staff members may be granted admitting clinical privileges. The privilege to admit shall be delineated and is not automatic. Patients shall be admitted only on the decision of a Medical Staff member who is a licensed practitioner permitted by the Commonwealth of Kentucky to admit patients to the Hospital.⁵⁰ Those in the Health Professional Staff shall not have hospital admitting privileges.

7.3 Basis for Clinical Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's prior and continuing education, training, experience, demonstrated current professional competence and judgment, clinical performance, utilization practice patterns, current physical and mental health status, and ability to exercise clinical privileges and responsibilities, with or without reasonable accommodations, the Hospital's capability and the availability of necessary resources to support the clinical privileges requested, adequate professional liability insurance coverage, and the documented results of patient care and other quality review and monitoring that the Medical Staff deems appropriate.

⁴⁷ EP6 MS.06.01.03

⁴⁸ EP14 MS.01.01.01

⁴⁹ EP2 MS.03.01.01

⁵⁰ EP13 MS.03.01.03

7.4 Delineation of Clinical Privileges in General

7.4.1 Clinical privileges shall be delineated in accordance with the degree of risk to the patient and denoted by the following classes:

- (a) Class 0: Health Professional Staff.
- (b) Class I: Diagnosis and therapy of minor illnesses, injuries or conditions, and performance of procedures with no threat to life.
- (c) Class II: Diagnosis and therapy of major illnesses, injuries, or conditions, and performance of procedures with minimal threat to life.
- (d) Class III: Diagnosis and therapy of major illnesses, injuries, or conditions, and performance of procedures, with possible serious threat to life.
- (e) Class IV: Diagnosis and therapy of unusually complex illnesses, injuries, or conditions and performance of procedures, with possible serious threat to life, within area of specialization.

7.4.2 Each applicant for appointment or reappointment to the Medical Staff must request the specific clinical privileges desired. All applications for clinical privileges, including modifications to existing clinical privileges, must be supported by documentation of training and/or experience to demonstrate current competence.

7.4.3 Each Medical Staff member shall exercise only those clinical privileges specifically recommended by the Credentials Committee and the MEC and approved by the University Health Care Committee. Whenever patient needs exceed the limits of clinical privileges granted, consultation is required.

7.4.4 A member of the Medical Staff with appropriate privileges shall manage and coordinate the patient's care, treatment and services.⁵¹ A physician member of the Medical Staff shall be responsible for the management and coordination treatment of any medical or psychiatric problem that may be present in a patient at the time of admission to the Hospital or that may arise during the hospitalization of the patient.⁵²

7.4.5 A Health Professional Staff member may exercise only those clinical privileges specifically granted by the Credentials Committee and the MEC and approved by the University Health Care Committee and may, subject to any licensure requirements or other legal limitations, exercise judgment within the areas of his/her professional competence. A Health Professional Staff member shall be directly responsible to the relevant Chair and must be supervised consistent with such member's license or certification and with applicable law, regulation and UK HealthCare policy, during patient treatment by the Medical Staff member attending the patient.

7.4.6 Medical Staff members desiring joint appointments shall have their requests to perform specific patient clinical services evaluated and specifically delineated by the clinical service(s) and specialty division(s) within which the clinical services of the

⁵¹ EP1 MS.03.01.03

⁵² EP3 MS.03.01.03

Medical Staff member will be provided.

7.5 Temporary Clinical Privileges⁵³

7.5.1 Upon receipt of a recommendation from the Credentials Committee following verification, including, but not limited to, those items listed in 7.7.2(a), below, and the President of the Medical Staff for appointment of an applicant to the Medical Staff or to the Health Professional Staff, and pending the recommendation by the MEC and approval by the University Health Care Committee, the Chief Clinical Officer, as authorized by the University Health Care Committee to act on its behalf, may grant temporary clinical privileges to such applicant at a particular Hospital not to exceed 120 calendar days. In the absence of the Chief Clinical Officer, the Executive Chief Medical Officer as his/her delegate, may grant such temporary clinical privileges. In exercising such temporary clinical privileges, the applicant shall act under the general supervision of the Chair. The Chief Clinical Officer shall notify, in writing, the Chief Operating Officer and the applicant of the specific temporary clinical privileges granted and their duration.

7.5.2 Temporary clinical privileges for an important care, treatment, and service need of a specific patient may be granted to a physician or dentist licensed to practice in the Commonwealth of Kentucky who is not an applicant for membership to the Medical Staff on the recommendation of the President of the Medical Staff, by the Chief Clinical Officer. Such temporary clinical privileges may be granted only after the Medical Staff Affairs Office has:

(a) Verified from appropriate licensing authorities, other institutions where the Practitioner has active medical staff membership and clinical privileges and from peer references, that the Practitioner possesses an appropriate, current, and unrestricted medical or professional Kentucky license; and that the Practitioner has appropriate education, training, experience, current competence, judgment, and clinical skills to perform the clinical privileges requested;

(b) Received from the physician or dentist the signed acknowledgment that he or she received and read copies of the Bylaws and the Behavioral Standards in Patient Care; and that the physician or dentist agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges;

(c) Received from the physician or dentist the signed acknowledgment that the granting of temporary clinical privileges shall not confer membership status; and

(d) Received verification from the issuing insurance company of malpractice insurance covering the Practitioner.

Such temporary clinical privileges shall be restricted to a period not to exceed 120 calendar days. No action will be taken on a request for temporary clinical privileges until such requirements are verified. This verification process does not constitute, nor is it synonymous with, a completed credentialing and privileging process that UK HealthCare uses when

⁵³ EP1, EP2, EP3, EP4, EP5 & EP6 MS.06.01.13; MS.06.01.11

credentialing members or prospective members seeking permanent clinical privileges.⁵⁴

7.5.3 Special conditions and requirements of supervision, proctoring and monitoring and reporting, as warranted and reasonable, may be imposed by the Chair or Credentials Committee on any physician or dentist granted temporary clinical privileges.

7.5.4 Temporary clinical privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Chief Clinical Officer, the Executive Chief Medical Officer, a Chief Medical Officer, the President of the Medical Staff, or the MEC.

7.5.5 Temporary clinical privileges may be immediately terminated at any time by the Chief Clinical Officer, the Executive Chief Medical Officer, a Chief Medical Officer or the President of the Medical Staff, who first shall notify the Chair and the Medical Staff Affairs Office, if practicable, before terminating temporary clinical privileges. In such cases, the appropriate Chair or in the Chair's absence, a Chief Medical Officer or President of the Medical Staff shall assign a member of the Medical Staff to assume the responsibility for the care of such Practitioner's patient(s). The wishes of the patient(s) shall be considered in the choice of a replacement Medical Staff member.

7.5.6 A Practitioner shall not be entitled to the procedural rights afforded by the Fair Hearing Plan if a request for temporary clinical privileges is refused or all or any portion of temporary clinical privileges is terminated or suspended.

7.5.7 All Practitioners requesting or receiving temporary clinical privileges shall be bound by the Governance Documents to the extent applicable to such Practitioners by the terms thereof.

7.6 Locum Tenens Clinical Privileges; Telemedicine Clinical Privileges.

Any Practitioner who provides locum tenens services or who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure, must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Bylaws. Such Practitioners may apply for clinical privileges through an application for appointment in the Courtesy or Voluntary categories, as appropriate. With respect to Practitioners providing treatment through a telemedicine link, the facility from which the activity originates must recommend the Practitioner. Clinical services offered via telemedicine shall be consistent with commonly accepted quality standards and recommended by a Medical Staff member as being appropriate for delivery via telemedicine.⁵⁵

7.7 Emergency Clinical Privileges

An emergency shall be considered as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In an emergency, any Medical Staff member with clinical privileges, to the extent permitted by his/her license and regardless of department,

⁵⁴ EP6, MS.06.01.13

⁵⁵ EP1 & EP2 MS.13.01.03

Medical Staff status, or clinical privileges, shall be permitted to do and be assisted by Hospital personnel in doing everything possible to save the life of a patient or save the patient from serious harm, using every facility of the Hospital if necessary, including calling for any necessary or desirable consultation. When the emergency no longer exists, the Medical Staff member must request any clinical privileges needed which he/she does not otherwise hold in order to continue to treat the patient. If such clinical privileges are denied or if the Medical Staff member does not wish to request such clinical privileges, the member's patient shall be assigned to an appropriate Active Medical Staff member.

7.8 Disaster Clinical Privileges⁵⁶

7.8.1 Disaster clinical privileges are granted only under the following circumstances:

- (a) The emergency management plan has been activated; and
- (b) The Hospital is unable to meet immediate patient needs.

7.8.2 Only the Chief Clinical Officer or designee with the concurrence of the President of the Medical Staff or the appropriate Chair is authorized to grant a request for disaster clinical privileges. Disaster clinical privileges may be terminated at any time by the Chief Clinical Officer in accordance with the Bylaws.

7.8.3 When clinical privileges are granted, volunteers considered eligible to practice in the Hospital must present valid government issued photo identification (driver's license or passport) and at least one of the following:

- (a) Current hospital identification of the professional designation,
- (b) Current license to practice,
- (c) Primary source verification of license,
- (d) Identification indicating membership on a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC) or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization,
- (e) Identification by a current Medical Staff member who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster, or
- (f) Identification that the individual has been granted authority to render care, treatment and services in disaster circumstances (such as those authorities granted by state, federal or municipal entities).

7.8.4 Each volunteer granted clinical privileges will be provided UK HealthCare identification that identifies the person as a volunteer with disaster clinical privileges.

7.8.5 Based on its oversight of each volunteer, a decision will be

⁵⁶ EP1, EP2, EP3, EP4, EP5, EP6, EP7, EP8 & EP9 EM.02.02.13

made within 72 hours of the volunteer's arrival if granted disaster privileges should continue.

7.8.6 Primary source verification of licensure will begin as soon as the immediate situation is under control or within 72 hours from the time the volunteer presents at the hospital, whichever comes first. If primary source verification of licensure cannot be completed within 72 hours of the volunteer's arrival due to extraordinary circumstances, it is performed as soon as possible and all of the following shall be documented:

(a) Reason(s) the primary source verification of licensure could not be performed within 72 hours of the volunteer's arrival,

(b) Evidence of the volunteer's demonstrated ability to continue to provide adequate care, treatment and services, and

(c) Evidence of the attempt to perform primary source verification as soon as possible.

7.8.7 All those granted disaster clinical privileges will be assigned a Medical Staff member to oversee care, treatment and services through appropriate venues such as direct observation, mentoring and clinical record review.

7.9 New Services and Programs

Any procedure or request for clinical privileges that is either new to the Hospital or that overlaps with more than one department will initially be reviewed by the Credentials Committee. The Credentials Committee may request information from one or more departments or Practitioners, or may create an ad-hoc committee as deemed necessary to establish credentialing criteria, or make recommendations regarding a request for clinical privileges for a new or transpecialty procedure. The recommendation of the Credentials Committee will be forwarded to the MEC for its review and action.

ARTICLE 8

PEER REVIEW ACTIVITIES

8.1 General

8.1.1 Peer review is performed to further patient safety and health care quality. Peer review may involve a variety of functions that monitor, assess, review, and evaluate Practitioners. Peer review may be warranted any time a Practitioner is implicated in a concern that affects, or could affect, patient safety or quality of care. All organizational units of the Medical Staff shall perform peer review and all Practitioners shall cooperate with any peer review activity. All peer review shall be conducted under the general authority of the Peer Review Committee. Medical Staff members are encouraged to report through appropriate leadership channels any actual or suspected issue or concern regarding a Medical Staff member's clinical practice. All Medical Staff members must read and comply with Medical Staff Affairs Office Departmental policies concerning peer review activities.

8.1.2 In accordance with KRS § 311.377, the committees and organizational entities duly constituted or authorized under these Bylaws and related Medical Staff documents shall perform the designated professional review functions and activities authorized

in these Bylaws and related Medical Staff documents.

8.1.3 All oral and written communications, reports, recommendations, actions and minutes made or taken by such committees or organizational entities are confidential and privileged pursuant to KRS § 311.377 and 42 U.S.C. § 299b-21 *et seq.*, and any subsequent state or federal laws that offer legal protections for credentialing, peer review and quality assurance activities.

8.1.4 All committees and organizational entities duly constituted or authorized under these Bylaws and related Medical Staff documents shall also be deemed to be “professional review bodies” as defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* (HCQIA). Peer review performed under authority of these Bylaws constitutes a Professional Review Activity as described by the HCQIA. All persons who participate in a Professional Review Activity shall be entitled to absolute immunity from civil liability for all conduct performed in good faith in furtherance of the Professional Review Activity to the fullest extent of the law, including specifically, but not exclusively the HCQIA and KRS § 311.377.

8.2 Collaborative Efforts and Progressive Improvement

8.2.1 The Medical Staff prefers and encourages the use of collaborative leadership efforts and progressive steps by Medical Staff leadership and Hospital management to address questions relating to an individual’s clinical practice, professional conduct, or health. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

8.2.2 Collaborative leadership efforts include:

(a) informal mentoring, coaching, or counseling by a Medical Staff leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records); and

(b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(c) Collaborative leadership efforts may be documented and maintained in the individual’s confidential file.

8.2.3 Progressive steps may include:

(a) addressing minor performance issues through Informational Letters;

(b) sending an Educational Letter that describes opportunities for improvement and provides specific guidance and suggestions;

(c) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of

the concern.

(e) All progressive steps shall be documented in a constructive manner and included in an individual's confidential file. Any written response to any of these progressive steps by the individual shall also be included in the individual's confidential file.

8.2.4 All of these efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with KRS § 311.377.

8.2.5 Collaborative leadership efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. When a question arises, the Medical Staff leaders and Hospital management may:

(a) address it pursuant to the collaborative leadership efforts and progressive steps provisions of this Section;

(b) refer the matter for review in accordance with another relevant policy; or

(c) refer it to the MEC for its review and consideration.

8.2.6 Medical Staff appointees do not have the right to be accompanied by counsel when the Medical Staff leaders and Hospital management are engaged in collaborative leadership efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve informal leadership efforts or progressive steps activities.

8.3 Professional Practice Evaluation Activities

Professional practice evaluation activities shall be conducted in accordance with any professional practice evaluation policies. A focused review is a quality improvement and peer review activity that involves an intensive, but non-adversarial, review of a Practitioner's performance to determine whether the Practitioner meets the standard of care, or whether the Practitioner may require additional education, training, or other appropriate action to improve performance and enhance quality of care and clinical outcomes or whether the Practitioner has competence in a specific privilege when UK HealthCare does not have documented evidence of such competence. Its goals are to assess and improve the Practitioner's clinical performance, rather than to discipline the Practitioner.

UK HealthCare uses ongoing professional practice evaluation to identify professional practice trends that might affect the quality of care and patient safety.

Matters that are not satisfactorily resolved through collegial intervention or through the professional practice evaluation policies shall be referred to the MEC for its review. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

8.4 Investigations

8.4.1 Initial Review:

(a) An issue or concern with a Practitioner may be referred to the Peer Review Committee if collaborative leadership efforts or progressive steps have not resolved an

issue, or when there is a single instance of such severity that in the discretion of Medical Staff leaders it requires further review. Referrals to the Peer Review Committee may regard the following, but are not limited to the following:

- (i) the clinical competence or clinical practice of any appointee to the Medical Staff, including the care, treatment or management of a patient or patients;
- (ii) the safety or proper care being provided to patients;
- (iii) the known or suspected violation by any appointee to the Medical Staff of applicable ethical standards or the Bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or
- (iv) conduct by any appointee to the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others.

(b) The Peer Review Committee may, at its discretion, accept referrals from other entities within the University. Any person making a referral for investigation will be informed of the Committee's decision whether to initiate an investigation, but in all other respect the investigation should be confidential.

(c) The Peer Review Committee shall conduct or arrange a threshold inquiry to determine whether the issue or concern raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) Actions taken pursuant to the Initial Review shall not constitute an investigation.

8.4.2 Investigation

(a) Issues or concerns with a Practitioner that are referred to the Peer Review Committee shall be reviewed to determine whether:

- (i) to conduct an investigation,
- (ii) to direct the matter to be handled pursuant to another policy, or
- (iii) to proceed in another manner.

(b) Prior to making its determination, the Peer Review may discuss the matter with the individual.

(c) An investigation shall begin only after a formal decision by the Peer Review Committee to do so. The Peer Review Committee's decision shall be recorded in the minutes for the meeting when the decision was made.

(d) The Peer Review Committee shall inform the individual in writing that an investigation has begun. The notification shall include:

- (i) the date on which the investigation was commenced;
- (ii) the persons on the committee that will be conducting the

investigation, if already identified;

(iii) a statement that the Practitioner will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and

(iv) a copy of these Bylaws, which outlines the process for investigations.

(e) The Peer Review Committee should inform the individual's Department Chair or Chief and Medical Staff leaders that an investigation has been commenced concerning the individual, along with a summary of the issue being investigated. However, in all other respects the investigation should remain confidential and should not be communicated to any person who does not have a clinical need to know about the investigation.

(f) Notification of an investigation may be delayed if the Peer Review Committee believes informing the individual would compromise the investigation or disrupt Hospital operations.

(g) An investigation may be conducted by the entire Peer Review Committee, a subset of the Peer Review Committee, or the Peer Review Committee may appoint an Ad Hoc Investigative Committee (AHIC) to conduct the investigation. The AHIC may include individuals not on the Medical Staff. Whenever an issue or concern relates to the clinical competence of the individual under review, the AHIC shall include a peer of the individual reasonably capable of analyzing the clinical issues under investigation.

(h) The scope of the investigation is not limited to the issues or concerns that initially gave rise to the investigation. The scope of the investigation may be expanded at any time.

(i) The AHIC may designate or engage one or more representatives to conduct investigative tasks. The AHIC and its representatives shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared, and, when determined to be appropriate, an interviewee may be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the AHIC's report.

(j) The AHIC shall also have available to it the full resources of the Medical Staff and the Hospital. The AHIC may request the Hospital seek an external review if:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the investigation would be aided by such an external review.

(k) If a decision is made to obtain an external review, the Practitioner under investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's

report.

(l) The AHIC may require a physical, mental, or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the AHIC or Peer Review Committee) allowing (i) the AHIC (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the AHIC. The cost of such health examination shall be borne by the Practitioner.

(m) The Practitioner under investigation shall have an opportunity to meet with the AHIC before it makes its report. Prior to this meeting, the Practitioner shall be informed of the issues or concern being investigated, but the AHIC may describe the issues or concerns in a general manner to preserve the integrity of the on-going investigation. The AHIC may also ask the Practitioner to provide written responses to specific questions related to the investigation or a written explanation of his or her perspective on the events that led to the investigation prior to the meeting. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. The Practitioner being investigated cannot be accompanied by legal counsel at this meeting.

(n) At the meeting, the Practitioner shall be invited to discuss, explain, or refute the issues or concerns that gave rise to the investigation or that have been identified by the AHIC during its review. A summary of the interview shall be prepared by the AHIC and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the AHIC believes it more accurately reflects what occurred at the meeting.

(o) The AHIC shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, unless an outside review is necessary. When an external review is necessary, the AHIC shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for a Practitioner to have an investigation completed within such time periods.

(p) At the conclusion of the investigation, the AHIC shall prepare a written report of the investigation to present to the Peer Review Committee. The report should include a summary of the investigation, including reference to any documentary evidence reviewed and witnesses interviewed. The report should list specific factual findings. The written report shall include recommendations to the Peer Review Committee on potential remedies or consequences appropriate to the findings.

(q) In making its recommendations, the AHIC shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the Practitioner, recognizing that fairness does not require that the Practitioner agree with the recommendation. Specifically, the AHIC may consider:

- appropriate;
- (i) relevant literature and clinical practice guidelines, as
 - (ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);
 - (iii) any information or explanations provided by the Practitioner under review; and
 - (iv) other information as deemed relevant, reasonable, and necessary by the AHIC.

8.4.3 Peer Review Committee Determination on the Investigation⁵⁷

(a) After the AHIC report is delivered, the Peer Review Committee shall meet as promptly as practical to review the AHIC report and deliberate over the report's findings and any recommendations. The Peer Review Committee may perform additional investigative tasks, or direct the AHIC to perform them, with supplemental reports as appropriate.

(b) The Peer Review Committee may accept, modify, or reject the findings and any recommendations it receives from the AHIC.

(c) The Peer Review Committee may close the investigation by making a determination on the AHIC report's findings and any recommendations, including any one or more of the following determinations:

- (i) determine that no action is justified;
- (ii) issue a letter of guidance, counsel, warning, or reprimand;
- (iii) impose conditions for continued appointment;
- (iv) impose a requirement for monitoring, proctoring, or consultation;
- (v) impose a requirement for additional training or education;
- (vi) recommend reduction of clinical privileges;
- (vii) recommend suspension of clinical privileges for a term;
- (viii) recommend revocation of appointment and/or clinical privileges; and/or
- (ix) make any other recommendation that it deems necessary or appropriate.

(d) All determinations by the Peer Review Committee shall be promptly forwarded to the MEC.

(e) If the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the Executive Vice President for

⁵⁷ EP6 & EP33 MS.01.01.01

Health Affairs shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(f) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

8.5 Precautionary Suspension or Restriction of Clinical Privileges⁵⁸

8.5.1 Grounds for Requesting Voluntarily Refraining or Precautionary Suspension:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of an individual, the President of the Medical Staff, in consultation with the Executive Chief Medical Officer, shall have the authority to:

(i) request that the Practitioner agree to voluntarily refrain from exercising privileges pending further review of the circumstances by the MEC in accordance with these Bylaws; or

(ii) if the Practitioner is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the Practitioner's clinical privileges as a precaution, which actions shall be reviewed by the MEC in accordance with these Bylaws.

(iii) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(b) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, restriction, or agreement.

(c) These actions shall become effective immediately, shall promptly be reported in writing to the Medical Staff Affairs Office by President of the Medical Staff, and shall remain in effect unless it is modified by President of the Medical Staff, in consultation with the Executive Chief Medical Officer.

(d) The Practitioner in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), within three (3) days of the imposition of the suspension.

8.5.2 The MEC shall review the matter within a reasonable time under the

⁵⁸ EP29 & EP32 MS.01.01.01

circumstances, not to exceed 14 days. As part of this review, the Practitioner shall be given an opportunity to meet with the MEC. The Practitioner shall not be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, closed-session minutes of the meeting shall be prepared.

8.5.3 After considering the matter resulting in a Practitioner's agreement to voluntarily refrain and the Practitioner's response, if any, the MEC shall determine the appropriate next steps, which may include, but are not limited to, commencing a focused review, referring the matter for review pursuant to another policy, initiate a formal investigation, or taking some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the agreement to voluntarily refrain or precautionary suspension should be continued throughout any further review process.

8.5.4 There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

8.5.5 Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff, or his/her delegate, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended Practitioner's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All appointees to the Medical Staff have a duty to cooperate with the President of the Medical Staff in enforcing precautionary suspensions or restrictions.

8.6 Exclusion from Hospital Premises

Nothing in this Article or these Bylaws shall prevent Hospital leadership from excluding a Practitioner from the premises of the Hospital as a precautionary measure to assure the health and safety of patients, Hospital personnel and guests or to prevent further disruption to the orderly operations of the Hospital. The scope and duration of such exclusion shall be at the discretion of the individual initiating the exclusion for the purpose stated herein. Such action shall not constitute an adverse action or professional review action and shall not entitle the affected Practitioner to any hearing or appeal rights set forth in this Section.

8.7 Automatic Relinquishment and Actions

8.7.1 Failure to Complete Medical Records. Failure to complete medical records, after notification of delinquency, shall result in automatic relinquishment of all clinical privileges (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage) unless the Practitioner satisfies a Chief Medical Officer that he/she has a justifiable excuse for such failure. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

8.7.2 Action by Government Agency or Insurer and Failure to Satisfy Threshold Criteria

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria set forth in these Bylaws, must be promptly reported by the Medical Staff appointee to Medical Staff office.

(b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in these Bylaws, if an individual fails to satisfy any of the threshold eligibility criteria set forth in these Bylaws on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:

(i) Licensure: Revocation, expiration, suspension, or the placement of restrictions on an individual's license, or an individual's license being placed on probationary status.

(ii) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.

(iii) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to cease to be in effect, in whole or in part.

(iv) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(v) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another; or (vii) the practitioner-patient relationship.

(c) Automatic relinquishment shall take effect immediately upon Special Notice to the individual and shall continue until the matter is resolved and the individual is reinstated, if applicable.

(d) If the underlying matter leading to automatic relinquishment is resolved within 30 days, the individual may request reinstatement. Failure to resolve the matter within 30 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

8.7.3 Failure to Complete or Comply with Training or Educational Requirements

(a) Failure to complete and/or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety, shall result in a requirement that the individual meet with the MEC to discuss the

individual's failure to complete/comply with the required content.

(b) Failure of the Medical Staff appointee to either: (i) meet with the MEC and convince it that the compliance is not necessary; or (ii) provide evidence of compliance prior to the meeting, will result in the automatic relinquishment of the individual's clinical privileges until the individual demonstrates completion or compliance with the relevant requirement. If the individual fails to do so within 30 days of the automatic relinquishment, the individual's Medical Staff appointment and clinical privileges will be deemed to have been automatically resigned.

8.7.4 Failure to Provide Requested Information

(a) Failure to provide information pertaining to a Medical Staff appointee's qualification for continued appointment or clinical privileges, in response to a written request, shall result in a requirement that the individual meet with the MEC to discuss why the requested information was not provided.

(b) Failure of the Medical Staff appointee to either meet with the MEC or provide the requested information prior to the meeting will result in the automatic relinquishment of the individual's clinical privileges until the information is provided to the satisfaction of the requesting party. If the individual fails to provide the information requested within 30 days of the automatic relinquishment, the individual's Medical Staff appointment and clinical privileges will be deemed to have been automatically resigned.

8.7.5 Failure to Attend Special Meeting

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff leader may require the individual to attend a special meeting with one or more of the Medical Staff leaders or with a committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The notice to the individual regarding this meeting shall be given by special notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Unless excused by the MEC upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the matter is resolved.

8.7.6 Request for Reinstatement

(a) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff office. If any questions or concerns are noted, the Medical Staff office will refer the matter for further review in accordance with (c) below.

(b) Requests for reinstatement following the relinquishment of clinical privileges due to (i) failure to provide requested information, (ii) failure to complete or comply with training, educational, or orientation requirements, and/or (iii) failure to attend a special meeting shall be reviewed by the President of the Medical Staff. If the President of the Medical

Staff recommends favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the MEC in accordance with (c) below.

(c) All other requests for reinstatement shall be reviewed by the MEC. If the MEC makes a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital.

ARTICLE 9 FAIR HEARING PLAN⁵⁹

9.1 In General

This ARTICLE 9 describes the Fair Hearing Plan afforded to applicants and members of the Medical Staff. In all cases, the Fair Hearing Plan, in both its description and application, shall be construed to comply with the provisions of the HCQIA so that all actions taken and all individuals who participate in any hearing shall be protected from liability and all information and documents shall be privileged to the maximum extent possible as afforded by the HCQIA. Accordingly, a Professional Review Action shall only be taken:

9.1.1 In the reasonable belief that the action was in the furtherance of quality health care,

9.1.2 After a reasonable effort to obtain the facts of the matter,

9.1.3 After adequate notice and hearing procedures are afforded to the Practitioner involved or after such other procedures as are fair to the Practitioner under the circumstances, and

9.1.4 In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph 9.1.3.

A Professional Review Action shall be presumed to have met the preceding standards necessary for the protection set out in this Section unless the presumption is rebutted by a preponderance of the evidence. The conduct of the appointment and reappointment process described in Section 6.2, above, a focused review conducted according to policy, and an investigation conducted under Section 8.4., above, shall constitute a reasonable effort to obtain the facts of the matter.

9.2 Professional Review Action Giving Rise to Right to a Hearing

9.2.1 Except as limited by Section 9.2.2, below, an applicant, an individual holding provisional clinical privileges, including a member of the Health Professional Staff, or an individual holding a Medical Staff appointment (the “Affected Individual”) shall be entitled to a hearing whenever any of the following Professional Review Actions against him/her has occurred:

(a) An adverse recommendation of the MEC in respect to

⁵⁹ EP34 MS.01.01.01; MS.10.01.01; EP2 & EP5 MS.06.01.09

appointment, reappointment or clinical privileges under Section 6.2.11, above;

(b) An adverse decision of the University Health Care Committee in respect to appointment, reappointment or clinical privileges under Section 6.2.12, above; or

(c) An adverse recommendation of the MEC following an investigation pursuant to Sections 8.4. and 8.5., above.

9.2.2 Notwithstanding the general list of actions that may give rise to a right to a hearing listed above, none of the following actions shall give rise to a right to a hearing or appeal, each of which shall take effect without hearing or appeal:

(a) A voluntary or automatic relinquishment of clinical privileges,

(b) The imposition of any requirement for retraining, additional training, or continuing education,

(c) Any reprimand, censure, warning, admonition, probation, proctorship or Professional Review Action that extends for less than 14 calendar days,

(d) Any reduction, restriction, suspension, revocation, denial or failure to renew of temporary, emergency or locum tenens clinical privileges,

(e) Any reduction, restriction, suspension, revocation, denial or failure to renew of clinical privileges due to a failure to meet the qualifications for Medical Staff membership set forth in Sections 3.2.1(b), 3.2.1(d), 3.2.1(e), 3.2.1(f), or 3.2.1(g), above,

(f) Any reduction, restriction, suspension, revocation, denial or failure to renew of clinical privileges due to incomplete or inaccurate application or reapplication information, whether imposed by the MEC or the University Health Care Committee,

(g) Any suspension or revocation of clinical privileges or membership to the Medical Staff as a result of being excluded or suspended from or being ineligible to participate in any Federal health care program or based upon a conviction of a criminal offense related to the provision of health care items or services,

(h) Any voluntary remedial action taken subject to a voluntary waiver by the Affected Individual of any right to a hearing or appeal, and

(i) Any failure to credential or grant privileges to someone who would not otherwise qualify for membership to the Medical Staff.

9.2.3 The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether through the Medical Staff or the University Health Care Committee, and the duties of the Hearing Panel shall be conducted subject to the procedures set forth in this Fair Hearing Plan.

9.3 Notice of Proposed Action⁶⁰

9.3.1 When a Professional Review Action is taken giving an Affected

⁶⁰ EP2 & EP5 MS.06.01.09

Individual the right to request a hearing under this Fair Hearing Plan, the President of the Medical Staff shall promptly give the Affected Individual notice of that Professional Review Action (the “Notice of Proposed Action”). The Notice of Proposed Action shall contain:

- (a) A statement of the Professional Review Action;
- (b) The reason(s) for the Professional Review Action;
- (c) Notification that the Affected Individual has the right to request a hearing on the Professional Review Action within 30 calendar days of receipt of the Notice of Proposed Action;
- (d) A summary of the Affected Individual’s rights in the hearing as provided for in this Fair Hearing Plan.

9.3.2 The Affected Individual shall have 30 calendar days following the date of receipt of the Notice of Proposed Action within which to request a hearing by providing written notice to the Chief Clinical Officer with a copy to the President of the Medical Staff. If the Affected Individual does not request a hearing within such 30 calendar days, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved, and such action shall thereupon become effective immediately upon final action by the MEC or the University Health Care Committee, as the case may be.

9.4 Notice of Hearing and Statement of Reasons

If a hearing is requested in a timely manner, the Chief Clinical Officer shall schedule the hearing and shall give notice (“Hearing Notice”) to the Affected Individual. The Hearing Notice shall: (i) include the time, place, and date of the hearing which date shall not be less than 30 calendar days after the date of the Hearing Notice; (ii) identify the Hearing Panel and the presiding officer; and (iii) include a list of proposed witnesses who may give testimony or evidence in support of the MEC or the University Health Care Committee at the hearing. The witness list may, at the discretion of the presiding officer, be amended or supplemented at any time including during the course of the hearing.

9.5 Hearing Panel⁶¹

If a hearing is requested in a timely manner, the Chief Clinical Officer shall appoint a Hearing Panel of not less than three members. The majority of the Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or physicians or lay persons not connected with UK HealthCare or either Hospital, or a combination of such persons and shall include at least one Active Medical Staff appointee whose primary site of practice is the same as the Affected Individual. The Hearing Panel shall not include any individual who is in direct economic competition with, or who is professionally associated with or related to the Affected Individual. The Chief Clinical Officer shall designate the chairperson of the Hearing Panel. Knowledge of the issues involved in the Professional Review Action shall not preclude any individual from serving as a member of the Hearing Panel.

⁶¹ EP35 MS.01.01.01

9.6 Presiding Officer

9.6.1 Appointment. The Chief Clinical Officer may appoint an attorney as presiding officer. Such presiding officer shall be engaged by the University at its expense but shall not be legal counsel to the Hospital or the University. He/she must not act as a prosecuting officer, or as an advocate for either side at the hearing. He/she may participate in the private deliberations of the Hearing Panel and serve as legal advisor to it, but he/she shall not be entitled to vote on its recommendations.

9.6.2 Chair of Hearing Panel. If no presiding officer has been appointed, the chairperson of the Hearing Panel shall be the presiding officer and shall be entitled to one vote.

9.6.3 Duties. The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and written evidence, that decorum is maintained throughout the hearing, and that no intimidation of witnesses is permitted. The presiding officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with this Fair Hearing Plan, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence.

9.7 Representation

9.7.1 The Affected Individual shall be entitled, at his/her own cost, to be represented at the hearing by an attorney or other person of the individual's choice, to examine witnesses and present his/her case. He/she shall inform the presiding officer in writing of the name and title of that person at least 10 calendar days prior to the date of the hearing.

9.7.2 If the Professional Review Action in question was taken by the MEC, the President of the Medical Staff shall present such adverse action during the hearing. If the Professional Review Action in question was taken by the University Health Care Committee, the chairperson of such committee or his/her designee shall present such adverse action during the hearing. The University General Counsel shall appoint an attorney, who may be legal counsel to the Hospital or the University to represent the MEC or the University Health Care Committee in support of such adverse action during the hearing and to examine and cross-examine witnesses at the hearing. Such attorney may thereafter continue to advise the University Health Care Committee and the University on the matter. The University General Counsel shall notify the Affected Individual of the appointment of such attorney.

9.7.3 Following appointment of an attorney or other representative for either party, each party shall provide copies of all notices and other documents and information required or permitted to be provided by such party to the presiding officer under this Fair Hearing Plan concurrently to such attorney or other representative.

9.8 List of Witnesses and Supporting Documentation

The Affected Individual shall provide to the presiding officer, within 10 calendar days after receiving the Hearing Notice, a list of proposed witnesses who will give testimony or evidence in support of the Affected Individual at the hearing. The witness list may, at the discretion of the presiding officer, be supplemented or amended at any time, including during the course of the hearing.

9.9 Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or by a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the Affected Individual at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation, such oath or affirmation to be administered by any person designated by the Hearing Panel and entitled to notarize documents in Kentucky. A recording of the Hearing shall not be maintained after transcription and approval of minutes.

9.10 Rights of Both Sides

At the hearing, both sides shall have the following rights: (i) to call and examine available witnesses, (ii) to introduce exhibits, (iii) to cross-examine any witness on any matters relevant to the issues, and (iv) to rebut any evidence. If the Affected Individual does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

9.11 Admissibility of Evidence; Written Statement

The hearing shall not be constrained by any court rules of evidence or procedure relating to the examination of witnesses or presentation of evidence. The "hearsay rule" shall not apply, and the sole standard for admissibility shall be relevancy to the charges or any offered defense or justification. Evidence may include medical charts and witnesses, either live or by deposition, as well as affidavits, witness statements, and any other documentary or physical evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement or memorandum of points and authorities, and the Hearing Panel may request such a statement or memorandum to be filed, following the close of the hearing. The Hearing Panel may, if it deems appropriate, interrogate the witnesses, call additional witnesses, or request documentary evidence.

9.12 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the state or federal courts in the Commonwealth of Kentucky. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

9.13 Burden of Proof

At any hearing conducted under this Fair Hearing Plan, the following rules governing the burden of proof shall apply:

9.13.1 The University Health Care Committee or the MEC, depending upon whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the Affected Individual to come forward with evidence in his/her support.

9.13.2 After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the MEC or the University Health Care Committee unless it finds that the Affected Individual has proved that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

9.14 Failure to Appear

Failure to appear and proceed at the hearing, without good cause, by the Affected Individual shall be deemed to constitute voluntary acceptance of the Professional Review Action, which shall then become final and effective immediately.

9.15 Attendance by Panel Member

Recognizing that it may not be possible for all members of the Hearing Panel to be present continually at all sessions of the hearing and that it is necessary to conduct a hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Hearing Panel are not present at all times during the hearing.

Such absences will not disqualify them or invalidate the hearing, so long as each voting member has read all transcripts or listened to all tape recordings of all proceedings. However, there shall be at least a majority of the members of the Hearing Panel present when the hearing sessions take place, and no member shall vote by proxy.

9.16 Postponements and Extensions

The presiding officer may permit on a showing of good cause, postponements and extensions of time requested by any of the involved parties.

9.17 Adjournment and Conclusion

The presiding officer may adjourn the hearing, and reconvene the same, at the convenience of the participants, without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

9.18 Deliberations and Recommendation of the Hearing Panel

Within 20 calendar days after final adjournment of the hearing, the Hearing Panel, including the presiding officer, shall conduct its deliberations outside the presence of any other person and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made, and be delivered to the Chief Clinical Officer. The decision of the Hearing Panel shall be based on the evidence produced at the hearing, including matters officially noticed. The Hearing Panel may also rely on written statements or memorandum of points and authorities presented in connection with the hearing. The Hearing Panel shall determine the probity of the evidence presented. The decision of the Hearing Panel shall be supported by the vote of a majority of those appointed to the Hearing Panel. Upon presentation of its recommendation and report, the Hearing Panel's obligation is fulfilled.

9.19 Disposition of Hearing Panel Report

Upon receipt, the Chief Clinical Officer shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the University Health Care Committee for further action. The Chief Clinical Officer shall also send a copy of the report and recommendation to the Affected Individual. If the hearing has been conducted by reason of an

adverse recommendation by the MEC, a copy of the report and recommendation of the Hearing Panel shall be delivered by the Chief Clinical Officer to the committee for information purposes.

9.20 Time for Appeal

Within 10 calendar days after the Affected Individual is notified of an adverse recommendation from the Hearing Panel, or an adverse recommendation from the University Health Care Committee modifying a recommendation from a Hearing Panel which was favorable to the Affected Individual, he/she may request an appellate review. The request shall be in writing, shall be delivered to the Chief Clinical Officer, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within 10 calendar days, the Affected Individual shall be deemed to have accepted the recommendation involved, and it shall thereupon become final and immediately effective. The Chief Clinical Officer shall notify the chairperson of the University Health Care Committee of receipt of the request for appeal.

9.21 Grounds for Appeal

The grounds for appeal from an adverse recommendation shall be that:

9.21.1 There was substantial failure on the part of the Hearing Panel, the MEC, or the University Health Care Committee to comply with this Fair Hearing Plan, so as to deny due process or a fair hearing.

9.21.2 The recommendations of the Hearing Panel or University Health Care Committee were made arbitrarily, capriciously, or with prejudice.

9.21.3 The recommendations of the Hearing Panel or University Health Care Committee were not supported by the evidence.

9.22 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the University Health Care Committee shall, within 10 calendar days after receipt of such request, schedule and arrange for an appellate review. The University Health Care Committee shall give the Affected Individual notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than 14 calendar days nor more than 40 calendar days from the date of receipt of the request for appellate review. However, when a request for appellate review is from an Affected Individual who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 calendar days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Chairperson of the University Health Care Committee.

9.23 Nature of Appellate Review

The Chairperson of the University Health Care Committee shall appoint a Review Panel composed of not less than three persons, either members of the University Health Care Committee or others, including but not limited to reputable persons outside UK HealthCare or either Hospital, or any combination of the same, to consider the record upon which the adverse recommendation was made. The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings.

Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he/she was deprived of the opportunity to admit it at the hearing, and then only at the discretion of the Review Panel. Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party's attorney or representative to appear personally and present oral argument. Such written statement shall be submitted to the Review Panel at least five business days prior to the scheduled date for the appellate review. The Review Panel shall recommend final action to the University Health Care Committee. The University Health Care Committee may affirm, modify, or revise the recommendation of the Review Panel.

9.24 Final Decision of the University Health Care Committee

Within 30 calendar days after receipt of the Review Panel's recommendation, the University Health Care Committee shall render a final decision in writing and shall deliver copies thereof to the Affected Individual and to the Chief Clinical Officer.

9.25 Right to One Hearing and One Appeal Only

No Affected Individual shall be entitled as a matter of right to more than one hearing and one appellate review on any single matter which may give rise to a right to a hearing and appeal. In the event that the University Health Care Committee ultimately determines to deny initial appointment or reappointment to the Medical Staff, or revokes or terminates the Medical Staff appointment and clinical privileges of an Affected Individual, that individual may not again apply for Medical Staff appointment or clinical privileges at UK HealthCare or either Hospital until after the expiration of two years from the date of such University Health Care Committee decision unless said committee provides otherwise in its written decision.

ARTICLE 10

CLINICAL SERVICES

The Medical Staff practicing at both Hospitals will be organized into clinical services as described below. The MEC may create, eliminate, subdivide or combine clinical services, subject to approval by the University Health Care Committee. Each clinical service will have a Chair.

10.1 Clinical Organization

10.1.1 Hospital Clinical Services. The clinical services shall be as follows:

Anesthesiology

Dentistry (Oral Health Practice and Oral Health Science)

Emergency Medicine

Family & Community Medicine

Internal Medicine

Neurology

Neurosurgery

Obstetrics/Gynecology
Ophthalmology and Visual Science
Orthopedic Surgery
Otolaryngology
Pathology and Laboratory Medicine
Pediatrics (does not include pediatric surgery)
Physical Medicine & Rehabilitation
Psychiatry
Radiation Medicine Radiology
Surgery
Urology

All clinical services performed at both Chandler Hospital and Good Samaritan Hospital shall be under the oversight and governance of the analogous clinical department in the UK College of Medicine, Dentistry or Public Health. However, not all clinical services must be performed at Good Samaritan Hospital, and any determination to the location in which clinical services may be performed shall be at the judgment of the MEC in consultation with the Chief Clinical Officer and University Health Care Committee.

10.1.2 Cancer Center. The Markey Cancer Center is recognized as a clinical service and the Director of the Lucille Parker Markey Cancer Center shall serve as its Chair. Active Faculty assigned to the Markey Cancer Center shall, in addition to their assignment to the clinical service that corresponds to the department of their primary faculty appointment, be assigned to the Markey Cancer Center clinical service.

10.1.3 Clinical Divisions at Good Samaritan Hospital. In the event that a clinical service within Good Samaritan Hospital is provided on an exclusive contractual basis, the MEC may establish a Clinical Division specific to the clinical operations of Good Samaritan Hospital.

(a) The Clinical Division shall be governed by the analogous clinical department in the UK College of Medicine, Dentistry or Public Health, but the division may be delegated such responsibilities as necessary to facilitate the operational needs unique to Good Samaritan Hospital. For example, if the MEC determines that anesthesia services shall be provided by an exclusive contract at Good Samaritan Hospital or that the volume of such services is substantial, then the MEC may establish a Good Samaritan Anesthesia Division to the general Anesthesia service. The Good Samaritan Anesthesia Division may be delegated a degree of autonomy to address operational needs specific to Good Samaritan Hospital, but the division shall otherwise be under the governance and authority of the Anesthesia clinical department that has primary responsibility for the anesthesia services at both hospitals.

(b) A Chief Medical Officer upon consultation with the President of the Medical Staff and the relevant Chair, may appoint a Good Samaritan Hospital Clinical Division Chief who shall report to the Chair of the associated clinical service. This appointment is administrative and may be removed at any time at the discretion of a Chief Medical Officer upon consultation with the President of the Medical Staff and the relevant

Chair. The Chief shall be board-certified or demonstrate equivalent competence affirmatively established through the credentialing process and shall be a member in good standing of the Active Medical Staff in such clinical service.

10.2 Assignment to Clinical Services

Each Medical Staff member shall be assigned to one clinical service by the MEC upon recommendation of the Credentials Committee, but may be granted clinical privileges in one or more other clinical services. The exercise of clinical privileges within any clinical service shall be subject to UK HealthCare policies and procedures, the policies and procedures of the clinical service, and the authority of the Chair. UK faculty shall be assigned to the clinical service that corresponds to the department of their primary faculty appointment.

10.3 Functions of Clinical Services

Subject to the authority of the MEC and University Health Care Committee, clinical services shall perform the following delegated functions:

10.3.1 Oversee the provision, evaluation, and improvement of quality patient care and periodically report to the MEC;

10.3.2 Require and provide appropriate continuing medical and professional education of Practitioners, residents, medical students, Health Professional Staff members, nursing, and other health personnel; and

10.3.3 Review and recommend for approval by the MEC and University Health Care Committee rules, regulations, policies, and standards regarding qualifications and requirements for determining current competence, credentialing, promotion of effective interdisciplinary communication and function, and governance. These recommendations must be consistent with the Governance Documents or expressly recommend an amendment to such inconsistent provisions of the Governance Documents.

10.4 Chairs of Clinical Service⁶²

10.4.1 Each Chair of a clinical service shall be board-certified or demonstrate equivalent competence affirmatively established through the credentialing process and shall be a member in good standing of the Active Faculty Medical Staff unless otherwise stated within these Bylaws.

10.4.2 The Chair of the academic department in the UK College of Medicine, Dentistry or Public Health shall be appointed as the Chair of the analogous clinical service unless the dean of the respective college determines that the Chair of the academic department shall not serve as Chair of the clinical service and, instead, appoints another person in the respective academic department in accordance with the selection qualification criteria and process described in the University Governing and Administrative Regulations.

10.4.3 Except as set forth in Section 10.1.3(b), above, the Chair may, in accordance with University regulations, policies and procedures, appoint chiefs of sections or divisions within a clinical service as may be appropriate for the effective and efficient

⁶² EP36 MS.01.01.01

operation of such clinical service.

10.4.4 If a Chair is unable to serve, resigns, or is removed, then the vacancy shall be filled in accordance with the procedures described in the University Governing and Administrative Regulations. Resignation and removal of a Chair shall be governed by the University Governing and Administrative Regulations.

10.5 General Duties of the Chair

10.5.1 Each Chair shall be responsible for the organization of the department and delegation of duties to department members to promote the best interests of patients. Members of departments shall be responsible to the Chair and, through him/her, to the President of the Medical Staff. Each Chair shall be responsible for:

- (a) All clinically related activities of the department,
- (b) All administratively related activities of the department, unless otherwise provided for by the Hospital,
- (c) Integrating the department into the primary functions of the Hospital,
- (d) Coordinating and integrating interdepartmental and intradepartmental services,
- (e) Developing and implementing policies and procedures that guide and support the provision of care, treatment and services,
- (f) Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services,
- (g) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department,
- (h) Recommending to the Medical Staff and/or the Credentials Committee the criteria for clinical privileges that are relevant to care provided in the department,
- (i) Recommending clinical privileges for each member of the department,
- (j) Determining the qualifications and competence of departmental staff who are not licensed to practice independently and who will provide patient care services,
- (k) Continuously assessing and improving the quality of care, treatment and services provided,
- (l) Maintaining quality control programs, as appropriate,
- (m) Orienting and providing in-service training and continuing education of all persons in the department,
- (n) Recommending space and other resources needed by the department,

(o) Assessing and recommending to the Chief Clinical Officer and the Chief Operating Officer off-site sources for needed patient care, treatment and services not provided by the department or the Hospital, and otherwise participating in the selection of sources for such needed services,

(p) Transmitting to the MEC department recommendations concerning appointment and classification, reappointment, and delineation of clinical privileges of Medical Staff members, Health Professional Staff and applicants, and corrective action with respect to Practitioners in the department; and

(q) Reporting clinically adverse incidents to the Peer Review Committee.

ARTICLE 11

OFFICERS OF MEDICAL STAFF

11.1 Identification of Officers and Terms⁶³

The officers of the Medical Staff shall be:

<u>Office</u>	<u>Term</u>
President of the Medical Staff	2 years, no more than 2 terms
President-Elect	2 years
Past President	Indefinite
Secretary	As appointed by the President of the Medical Staff

11.2 Qualifications of Officers⁶⁴

Each officer of the Medical Staff, other than the Secretary, must be a member of the Active Medical Staff at the time of his/her nomination and election, and must remain a member of the Active Medical Staff in good standing during his/her term of office. Failure to maintain such status shall automatically create a vacancy in the office involved. The Secretary shall be appointed by the President of the Medical Staff and shall serve ex-officio, without vote. No individual may hold more than one office at any time.

11.3 Nominations and Elections⁶⁵

Biennially, in even numbered years, the Nominating Committee shall prepare a slate of nominees for each of the positions of President and President-Elect of the Medical Staff to be filled at a regular or special meeting of the Organized Medical Staff held for this purpose. Nominations may also be made by petition for the office of President of the Medical Staff signed by at least 10% of the members of the Active Medical Staff with a signed statement of willingness to serve by the nominee filed with the President of the Medical Staff at least 30

⁶³ EP19 MS.01.01.01

⁶⁴ EP1 MS.03.01.01

⁶⁵ EP18 MS.01.01.01

calendar days before the meeting. No nominations shall be made from the floor during the meeting. Voting will be by electronic ballot unless electronic voting is not feasible, in which case voting will be by written ballot. Voting by proxy shall not be permitted. The President of the Medical Staff will be elected by a majority vote of the Organized Medical Staff casting ballots. If no candidate receives a majority vote in the election for the specified position, a run-off election by electronic ballot shall be held between the two candidates receiving the highest number of votes, and the candidate receiving the highest number of votes of the Organized Medical Staff casting ballots in such run-off election shall be elected for that position.

11.4 Vacancies in Elected Office

Vacancies in the office of President-Elect shall be filled by appointment made by the President of the Medical Staff with MEC approval. A vacancy in the office of President of the Medical Staff shall be filled by appointment by the majority vote of the MEC. Pending such appointment, a Chief Medical Officer shall serve as interim President of the Medical Staff.

11.5 Resignations and Removals⁶⁶

Any officer may resign at any time by giving written notice to the MEC and, unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. The death of an officer shall be deemed to constitute resignation. Any officer may be removed by the MEC for failure to perform the duties of the position at a special meeting called for such purpose. A petition for removal shall be submitted to a Chief Medical Officer by at least 50% of the MEC and, upon receipt thereof, a Chief Medical Officer shall call a meeting of the MEC to be held within 30 calendar days to consider and act upon the petition. An officer shall be removed upon receiving at least a two-thirds majority of the valid votes cast at the meeting of the MEC in favor of removal. If an officer resigns or is removed, his/her successor shall be filled in the same manner as any other vacancy.

11.6 Duties of Officers

11.6.1 President of the Medical Staff⁶⁷ The President of the Medical Staff shall have general overall supervision of the affairs of the Medical Staff. Duties of the President of the Medical Staff shall include, but are not limited to:

- (a) Together with a Chief Medical Officer, performing the oversight activities of the Organized Medical Staff;
- (b) Performing the duties of the President of the Medical Staff otherwise described in these Bylaws;
- (c) Serving as a voting member and as chair of the Medical Staff Executive Committee;
- (d) Calling, presiding at and being responsible for the agenda of

⁶⁶ EP18 MS.01.01.01

⁶⁷ EP1 & EP3 MS.03.01.01

Medical Staff meetings;

(e) Developing and implementing, in conjunction with Chairs, the Executive Chief Medical Officer, and a Chief Medical Officer, methods for credentials review, delineation of clinical privileges, educational programs, utilization management, and performance improvement;

(f) Communicating and representing the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Executive Chief Medical Officer, a Chief Medical Officer, and the University Health Care Committee;

(g) Ensuring review and enforcement of these Bylaws;

(h) Acting as representative of the Medical Staff to the public, as well as to other healthcare providers, other organizations, the University Health Care Committee, and government and voluntary organizations;

(i) Appointing and discharging chairs and members of all Medical Staff committees, except the MEC, and select members of the Peer Review Committee, and serve as ex-officio member with vote of all Medical Staff committees, except the Peer Review Committee where the President of the Medical Staff shall serve as ex-officio member without vote;

(j) Receiving and interpreting the opinions, policies, and directives of Administration and the University Health Care Committee to the Medical Staff; and

(k) Delegating duties and activities as deemed necessary and appropriate.

11.6.2 President-Elect. The President-Elect shall, in the absence of the President of the Medical Staff, fulfill the duties of the President of the Medical Staff. In addition, the President-Elect will automatically become the President at the next term. The President-Elect shall perform such duties as may be delegated by the President of the Medical Staff.

11.6.3 Secretary. The Secretary shall serve as staff to the MEC, attend to all correspondence and perform other such duties as ordinarily pertain to the office of Secretary, and perform such duties as may assigned by the President of the Medical Staff. The Secretary shall cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings, and record attendance.

ARTICLE 12

COMMITTEES AND FUNCTIONS

12.1 Medical Staff Executive Committee⁶⁸

12.1.1 Responsibility and Authority⁶⁹

⁶⁸ EP20 MS.01.01.01

⁶⁹ EP20 & EP23 MS.01.01.01; EP5 MS.02.01

(a) The MEC is charged with the delegated responsibility from the Medical Staff and the University Health Care Committee for self-governing the members of the Medical Staff, and for overseeing the performance of clinical programs including the quality, safety and efficiency of care and treatment, as well as the coordination of activities between Medical Staff and Hospital clinical services to promote communication and improve function and clinical outcomes throughout UK HealthCare. The MEC is empowered and expressly delegated the responsibility and authority to the fullest extent permitted by law and standards of accreditation, to transact business on behalf of the Medical Staff and to act for the Organized Medical Staff between meetings of the Organized Medical Staff, which shall include but not be limited to:

(i) Developing a single, standard credentialing package to be used by all Practitioners applying for Medical Staff membership;

(ii) Reviewing, adopting, approving and modifying medical policy, procedures, and programs;

(iii) Promoting medical ethics and patient rights;

(iv) Establishing the overarching policies and procedures governing all of the clinical activity, including appropriate standards of care, within UK HealthCare;

(v) Overseeing the performance of clinical services by all Practitioners (including residents and licensed practitioners), including quality, safety, outcomes, efficiency and assessment of needs;

(vi) Ensuring that UK HealthCare meets or exceeds the performance standards for accreditation and compliance with local, state and federal law; and

(vii) Enforcing compliance with the Bylaws and with UK HealthCare policies and procedures.

(b) The MEC shall receive and act on reports and recommendations from Medical Staff committees, clinical services, and assigned activity groups.⁷⁰ The MEC shall be responsible for making recommendations on matters pertaining to Medical Staff and related issues directly to the University Health Care Committee for its approval. Recommendations shall include, but not be limited to:

(i) Granting Medical Staff membership (initial appointment and reappointment);⁷¹

(ii) The structure of the Organized Medical Staff and the Active Medical Staff;⁷²

⁷⁰ EP6 & EP12 MS.02.01.01

⁷¹ EP8 MS.02.01.01

⁷² EP9 MS.02.01.01

privileges;⁷³

- (iii) The process used to review credentials and delineate

- (iv) The specific delineation of clinical privileges for each licensed practitioner, based on demonstrated competency and performance review;⁷⁴

- (v) The participation of the Medical Staff in organization performance improvement, risk management and compliance activities; and

- (vi) Enforcement of voluntary remediation, disciplinary, and corrective action, including revocation and termination of membership and clinical privileges.

12.1.2 Composition.⁷⁵

- (a) The MEC shall consist of the following voting members with additional details in policy and the MEC Charter:

- (i) President of the Medical Staff

- (ii) President-Elect

- (iii) Nine other representatives, as defined by the MEC Charter and elected by the Organized Medical Staff as described in Section 12.1.3, below.

- (iv) Four Chief Medical Officer(s)

- (v) Three at-large members

- (vi) Chair of the Credentials Committee

- (vii) Chair of the Peer Review Committee

- (b) In addition to the voting members, the following shall serve as ex officio members without vote:

- (i) Chief Clinical Officer

- (ii) Dean, College of Medicine

- (iii) ACGME Designated Institutional Official or designee⁷⁶

- (iv) Chief Nurse Executive

- (v) Dean, College of Dentistry

⁷³ EP10 MS.02.01.01

⁷⁴ EP11 MS.02.01.01

⁷⁵ EP22 MS.01.01.01; EP2 & EP4 MS.02.01.01

⁷⁶ EP5 & EP6 MS.04.01.01

- (vi) Chief Operating Officer
- (vii) Chief Medical Information Officer
- (viii) All non-voting Department Chairs or their designee
- (ix) Vice President for Ambulatory Services and Medical Group Operations Executive Chief Medical Officer
- (x) Chief Digital & Information Officer

12.1.3 Nominations.⁷⁷ Biennially in even-numbered years, the Nominating Committee shall prepare a slate of nominees for each at-large member of the MEC to be filled at a regular or special meeting of the Organized Medical Staff held for this purpose. Nominations may also be made by petition for at-large members of the MEC signed by at least 10% of the appointees of the Active Medical Staff, with a signed statement of willingness to serve by the nominee filed with the President of the Medical Staff at least 30 calendar days before the meeting. No nominations shall be made from the floor during the meeting. Voting will be by electronic ballot unless electronic voting is not feasible, in which case voting will be by written ballot. Voting by proxy shall not be permitted. The nominees for at-large membership on the MEC in each of the three qualifying categories receiving the highest number of votes of the Organized Medical Staff shall be elected to the MEC.

12.1.4 Meetings. The MEC shall meet as often as necessary to discharge fully its duties and responsibilities in a timely, efficient manner. Minutes of the MEC shall be forwarded to the University Health Care Committee. A majority of members of the MEC attending and capable of voting shall constitute a quorum. The action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of the MEC. At times appropriate and necessary, the MEC may take action without a meeting by electronic vote with at least 70% participation of voting members. Consent may be provided either in writing and signed by the member or electronically through a secure system operated by the University of Kentucky that requires verification of identity of the member sending the consent. Electronic consent shall be submitted to the Secretary.

12.1.5 Vacancies. Vacancies on the MEC shall be filled by appointment made by the President of the Medical Staff with MEC approval.

12.1.6 Resignations and Removals.⁷⁸ Any member of the MEC may resign at any time by giving written notice to the President of the Medical Staff and, unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. The death of a member shall be deemed to constitute resignation. Any member may be removed by the MEC for failure to perform the duties of the position at a special meeting called for such purpose. A petition for removal shall be submitted to the President of the Medical Staff by at least 50% of the voting members of the MEC and, upon receipt thereof, the President of the Medical Staff shall call a meeting of the MEC to be held within 30 calendar days to consider and act upon the petition. A member shall be removed upon receiving at least a two-thirds

⁷⁷ EP21 MS.01.01.01⁸⁸ EP3 MS.02.01.01

⁷⁸ EP21 MS.01.01.01

majority of the valid votes cast at the meeting of the MEC in favor of removal. If a member resigns or is removed, his/her successor shall be filled in the same manner as any other vacancy.

12.2 Credentials Committee and Privileging Subcommittee(s)

12.2.1 Responsibility and Authority. The Credentials Committee is a standing subcommittee of the MEC that has been delegated the authority to recommend initial appointment and reappointment to the Medical Staff and the Health Professional Staff and clinical privileges. The Credentials Committee may form Privileging Subcommittee(s). Such Privileging Subcommittee(s) shall be responsible for reviewing applications for clinical privileges and recommending to the Credentials Committee action to be taken on such applications. The Director of Medical Affairs, appointed by a Chief Medical Officer, subject to the approval of the Executive Chief Medical Officer, shall serve as Chair of the Credentials Committee. The Credentials Committee and any Privileging Subcommittee(s) may consist of the same members and meet at the same time.

12.2.2 Composition. The President of the Medical Staff upon consultation with a Chief Medical Officer shall appoint the members of the Credentials Committee and any Privileging Subcommittee(s) with the concurrence of the Chair of the Credentials Committee. The appointment is administrative and may be removed at any time in the discretion of the President of the Medical Staff upon consultation with a Chief Medical Officer with the concurrence of the Chair of the Credentials Committee.

12.3 Nominations Committee

The Nominations Committee shall be composed of the President of the Medical Staff, the Chief Operating Officer, the Chief Clinical Officer or the Executive Chief Medical Officer on his or her behalf, the Chief Nurse Executive, one Chief Medical Officer selected by the Executive Chief Medical Officer, and six Chairs appointed by the President of the Medical Staff. The appointment is administrative and may be removed at any time in the discretion of the President of the Medical Staff. The Nominations Committee shall be responsible for nominating candidates for Medical Staff officers and for the at-large members of the MEC.

12.4 Peer Review Committee

12.4.1 Responsibility and Authority. The Peer Review Committee is a standing subcommittee of the MEC that has been delegated the authority to oversee and be responsible for the safety and quality oversight activities of the Medical Staff and the Health Professional Staff, including, but not limited to, focused reviews, ongoing professional practice evaluations and general peer review activities, which, with respect to initial appointments, reappointments and clinical privileges, may be utilized by the Credentials Committee as necessary to perform its functions. To the fullest extent permitted by law, the Peer Review Committee may create or access any information necessary to perform its peer review functions for the purpose of improving the safety and quality of health care delivery.

12.4.2 Composition. The Peer Review Committee shall consist of the following voting members:

- (a) President-Elect
- (b) Chair of the Credentials Committee

- (c) Medical Director of Risk Management
 - (d) Senior Associate Dean of Faculty Affairs
 - (e) Physician Chair of the UK HealthCare Quality and Safety
- Committee
- (f) Director of the Office of Advanced Practice
 - (g) Chair of the Peer Review Committee appointed by the President of the Medical Staff upon consultation with a Chief Medical Officer. The appointment is administrative and may be removed at any time in the joint discretion of the President of the Medical Staff and a Chief Medical Officer.

(h) Four at-large members appointed by the President of the Medical Staff upon consultation with a Chief Medical Officer who serve a two-year term with no term limits. This appointment is administrative and may be removed at any time in the joint discretion of the President of the Medical Staff and a Chief Medical Officer. Membership is reviewed biannually.

In addition to the voting members, the following shall serve as ex officio members without vote:

- (i) Chair of the Practitioner under review
 - (j) President of the Medical Staff
 - (k) A Chief Medical Officer as designated by the Executive Chief
- Medical Officer
- (l) UK HealthCare Chief Compliance Officer
 - (m) Assistant Vice President for Office of Equal Opportunity
 - (n) Director of Risk Management
 - (o) Other ad hoc personnel as determined by the chair of the Peer
- Review Committee

12.4.3 Meetings. The presence of a majority of members of the Peer Review Committee entitled to vote, present and attending, shall constitute a quorum for all actions. If an appropriate quorum is not present, the meeting may be adjourned by those members in attendance and reconvened at such later date as determined by the chair of the Peer Review Committee when a quorum is available and is present. At times appropriate and necessary, the Peer Review Committee may take action without a meeting by unanimous consent of all voting members, provided that the consent sets forth the action taken. Consent may be provided either in writing and signed by the member or electronically through a secure system operated by the University of Kentucky that requires verification of identity of the member sending the consent. Electronic consent shall be submitted to the Secretary.

12.4.4 Resignations. The chair of the Peer Review Committee or at-large member may resign at any time by giving written notice to the President of the Medical Staff and unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. The death of the chair or at-large member shall be deemed to constitute resignation. If

the chair or at-large member resigns, his/her successor shall be filled by appointment made by the President of the Medical Staff upon consultation with a Chief Medical Officer.

12.4.5 Recusal. The chair of the Peer Review Committee has discretion to recuse a member if the chair determines the member's presence would:

- (a) Inhibit the full and fair discussion of the issue,
- (b) Skew the recommendation or determination of the Peer Review

Committee, or

- (c) Otherwise be unfair to the Practitioner under review.

12.5 Other Committees

12.5.1 Other Standing Committees of the Medical Staff. The responsibilities, duties and charges of such committees shall be further described in UK HealthCare policies and plans. Other ad hoc committees of the Medical Staff may be formed from time to time by the MEC or by the Organized Medical Staff as may be appropriate or prudent for the safe and efficient provision of patient care, treatment and services. Each standing and ad hoc committee shall have a chair or co- chairs, at least one of whom shall be a member of the Medical Staff. The members and chairs of such standing and ad hoc committees (i) shall be appointed by the President of the Medical Staff upon consultation with the Executive Chief Medical Officer, subject to the approval of the MEC and the Chief Clinical Officer and (ii) shall serve a two-year term with no term limits. Members of these other standing and ad hoc committees may include the President of the Medical Staff, the Executive Chief Medical Officer, a Chief Medical Officer as designated by the Executive Chief Medical Officer, the Chief Clinical Officer or the Chief Operating Officer as the designee of the Chief Clinical Officer as ex-officio members. The appointment to such committees is administrative and may be removed at any time in the joint discretion of the President of the Medical Staff and the Chief Clinical Officer.

12.5.2 Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee shall be responsible for overseeing the effective and efficient operation of the formulary system and drug policy development. The Pharmacy and Therapeutics Committee assists in the formulation of broad professional policies relating to drugs throughout UK HealthCare, including their evaluation, selection, prescribing, procurement, storage, distribution, administration, monitoring, and use.

12.5.3 Infection Prevention and Control Committee. The Infection Prevention and Control Committee shall be responsible for the surveillance of health care enterprise infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of UK HealthCare activities.

12.5.4 UK HealthCare Quality and Safety Committee. The UK HealthCare Quality and Safety Committee shall be responsible for overseeing the quality and safety of medical staff practice at UK HealthCare and each of the Hospitals. This Committee may convene in collaboration with the Excel Implementation Committee. The chair of the UK HealthCare Quality and Safety Committee shall be the Chief Quality and Safety Officer or designee.

12.5.5 Transfusion Committee. The Transfusion Committee shall review blood

usage.

12.5.6 Operating Room and Procedural Area Committee. The Operating Room and Procedural Area Committee shall oversee proper utilization of the operating rooms and recommend and enforce rules and regulations for the operating room areas to a Chief Medical Officer and the MEC.

12.5.7 Ethics Committee. The Ethics Committee shall be multidisciplinary in character and shall serve as an advisory resource for the Medical Staff, UK HealthCare, and the community, addressing issues of medical ethics.

12.5.8 ICU Committee. The duties of the ICU Committee will include coordination and leadership of the activities of the various units and supporting programs for quality care of patients; supervision of the quality of care programs of the units and Enhanced Care through Advanced Technology Intensive Care Unit (eCAT); and to monitor, document, and continually improve the care provided at the Hospitals. The committee may consult all persons or entities within UK HealthCare and the University in pursuit of effective patient care and management including Medical Staff and Hospital committees, Medical Staff members, divisions, and departments, and Hospital departments and administrators.

12.5.9 Cancer Committee. The Cancer Committee serves as the oversight committee for all cancer-related activities within UK HealthCare. This committee is charged with assuring the appropriate organization, environment, and services required to provide optimal cancer patient care and professional education through an academic comprehensive cancer program designed to meet the requirements of the Commission on Cancer of the American College of Surgeons.

12.5.10 Nutrition Committee. The Nutrition Committee shall be responsible for review and analysis of clinical nutrition care of hospitalized patients including nutrition by the oral, enteral, or parenteral route. The committee will develop and recommend methods of nutritional assessment and evaluation, nutrition care products and services used, and nutrition quality assurance monitors, and serve as the review and approval body for various clinical nutrition-related operational and educational manuals.

12.5.11 Resuscitation Committee. The Resuscitation Committee serves as the oversight committee for code blue response processes. The committee will develop and provide education specific to resuscitation response. This committee will review and analyze practice changes and trends associated with published guidelines, institutional data and code blue activations.

12.5.12 Laboratory Formulary Committee. The Laboratory Formulary Committee oversees all efforts to optimize laboratory test utilization for UK HealthCare. The Laboratory Formulary Committee is responsible for: (i) evaluating the clinical appropriateness of laboratory tests, and (ii) developing policies and protocols to promote appropriate laboratory utilization.

12.5.13 Clinical Guidelines and Protocols Committee. This Committee governs the development, approval, implementation and oversight of order sets, order sets and protocols for medication, and care management across UK HealthCare. The Committee will collaborate with medical staff, nursing, pharmacy, and other allied health leadership to ensure compliance with clinical standards, safety regulations, and evidence-based practice.

12.5.14 Protocol Review Committee. The Protocol Review Committee is a multidisciplinary committee that review standing orders, guidelines, and protocols.

ARTICLE 13

MEDICAL STAFF MEETINGS

13.1 Meetings

13.1.1 Annual Meeting. The Organized Medical Staff shall meet at least annually. The order of business to be considered at the annual meeting shall include without limitation, election of officers and committee members and consideration of amendments to the Bylaws, if any. Other items of business shall be included upon the written request of at least 10% of the Organized Medical Staff delivered to the President of the Medical Staff at least 30 calendar days prior to such meeting. Prior to such meeting, the President of the Medical Staff shall notify the MEC of any rule, regulation, policy or amendment thereto requested to be considered by the Organized Medical Staff.⁷⁹

13.1.2 Special Meetings. A Chief Medical Officer, the President of the Medical Staff or the President-Elect may call a special meeting of the Organized Medical Staff at any time. The President of the Medical Staff shall call a special meeting within 30 calendar days after receipt of a written request for same, signed by not less than 10% of the Organized Medical Staff and stating the purpose of such meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Prior to such meeting, the President of the Medical Staff shall notify the MEC of any rule, regulation, policy or amendment thereto requested to be considered by the Organized Medical Staff.⁸⁰

13.1.3 Notice. Notice stating the purpose, place, day, and hour of the annual and any special meeting of the Organized Medical Staff shall be delivered to each member of the Medical Staff not less than 15 calendar days before the date of such meeting or with respect to any meeting during which an election shall be held not less than 45 calendar days before the date of such meeting, by or at the direction of the President of the Medical Staff (or other persons authorized to call the meeting). The members of the Organized Medical Staff entitled to attend and vote at any meeting of the Organized Medical Staff shall be determined by the CMO Office not more than 30 calendar days before the delivery of notice of the meeting.

13.2 Quorum⁸¹

The presence of at least 20 Organized Medical Staff members entitled to vote, present and attending, shall constitute a quorum for all actions. If an appropriate quorum is not present, the meeting may be adjourned by those members in attendance and reconvened at such later date as determined by the President of the Medical Staff when a quorum is available and is present. Alternatively, except with respect to matters that may not be delegated, the MEC shall, at its

⁷⁹ EP9 MS.01.01.01

⁸⁰ EP9 MS.01.01.01

⁸¹ EP23 MS.01.01.01

next meeting, act for the Organized Medical Staff on all issues requiring vote.

13.3 Parliamentary Authority

All meetings of the Organized Medical Staff shall be conducted according to Robert's Rules of Order, Revised, except in cases where such rules are inconsistent with these Bylaws.

13.4 Manner of Action

The action of a majority of the Organized Medical Staff entitled to vote present at a meeting at which a quorum is present shall be the action of the Medical Staff. With respect to elections and amendments to bylaws, if feasible, voting may be conducted electronically and votes so cast shall be counted toward the quorum for such meeting. An electronic vote shall provide the opportunity to vote by submitting an electronic ballot through a secure system operated by the University of Kentucky.

13.5 Minutes

Minutes of each Organized Medical Staff meeting shall be prepared and signed by the Secretary, and copies thereof shall be promptly submitted to the President of the Medical Staff, and thereafter made available to all Medical Staff members.

ARTICLE 14

PRIVILEGES AND IMMUNITIES

Each applicant for appointment to the Medical Staff or the Health Professional Staff, each member of the Medical Staff, each member of the Health Professional Staff and each other person having or seeking clinical privileges to practice his/her profession or to render specified clinical services in a Hospital or otherwise within UK HealthCare (an "Applicant/Practitioner") agrees that the provisions of this Article shall specifically control with regard to his/her relationship to the members of the Medical Staff and each of its committees, the members of the Health Professional Staff, the members of Administration, the members of the University Health Care Committee, the UK Board of Trustees and the University and each of their respective representatives (each, a "UK Party"). By submitting an application for membership in the Medical Staff or Health Professional Staff or for clinical privileges, by accepting appointment or reappointment to the Medical Staff or Health Professional Staff or clinical privileges, by exercising clinical privileges, including temporary clinical privileges, and by seeking to render and rendering specified clinical services within UK HealthCare, each Applicant/Practitioner specifically agrees to be bound by the provisions of this Article during the processing of his/her application and at all times thereafter, and such provisions shall continue to apply during his/her appointment or reappointment.

14.1 Privilege

Any act, communication, report, recommendation or disclosure with respect to such Applicant/Practitioner, performed, given or made in good faith and without actual malice and at the request of any authorized representative of the University of Kentucky, including its clinical enterprise known as UK HealthCare or any other healthcare facility or provider for the purpose of providing, achieving and maintaining quality patient care within UK HealthCare, including in the Hospitals or at any other healthcare facility shall be privileged to the fullest

extent permitted by law, including all privileges afforded by KRS §311.377. Such privilege shall extend to each UK Party and to third parties who furnish information to any UK Party authorized to receive, release or act upon such information. Such privilege shall apply to any act, activity, or process described in these Bylaws and any associated communication, report, recommendation, or disclosure carried out for such purpose, including, without limitation, those relating to:

14.1.1 Applications for appointment to the Medical Staff or Health Professional Staff or for clinical privileges or specified clinical services,

14.1.2 Periodic appraisals or reviews for reappointments, clinical privileges, or specified clinical services,

14.1.3 Focused reviews, ongoing professional practice evaluations, designated professional review functions, other reviews and investigations, voluntary remediation and practitioner assistance,

14.1.4 Corrective action, including Precautionary Suspensions or revocations and limitations of clinical privileges or membership,

14.1.5 Investigations, hearings and appellate reviews,

14.1.6 Medical care evaluations,

14.1.7 Peer review activities or evaluations,

14.1.8 Utilization management, and

14.1.9 Any other Hospital, clinical service, or committee activities related to quality patient care, professional conduct, or professional relations.

Third parties shall include individuals, firms, corporations and other groups, entities or associations from whom information has been requested or to whom information has been given by a member of the Medical Staff, authorized representatives of the Medical Staff, the Administration or the University Health Care Committee.

14.2 Immunity

To the fullest extent permitted by law, including the HCQIA and KRS § 311.377, each UK Party shall have absolute immunity from civil liability to Applicant/Practitioner arising from any such act, communication, report, recommendation, or disclosure performed, given or made, even if the information involved would otherwise be privileged. No action, cause of action, damage, liability or expense shall arise or result from or be commenced by Applicant/Practitioner against any UK Party with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations, and disclosures performed, given or made in connection with or for or on behalf of any activities of UK HealthCare or of any other healthcare facility or provider including, without limitation, those relating to:

14.2.1 Applications for appointment to the Medical Staff or Health Professional Staff or for clinical privileges or specified clinical services,

14.2.2 Periodic appraisals or reviews for reappointments, clinical privileges, or specified clinical services,

14.2.3 Focused reviews, ongoing professional practice evaluations, designated professional review functions, other reviews and investigations, voluntary remediation and practitioner assistance,

14.2.4 Corrective action, including Precautionary Suspensions or revocations and limitations of clinical privileges or membership,

14.2.5 Investigations, hearings and appellate reviews,

14.2.6 Medical care evaluations,

14.2.7 Peer review activities or evaluations,

14.2.8 Utilization management, and

14.2.9 Any other Hospital, clinical service, or committee activities related to quality patient care, professional conduct, or professional relations.

14.3 Scope

The acts, communications, reports, recommendations and disclosures referred to in this Article may concern, involve, or relate to, without limitation, the Applicant/Practitioner's professional qualifications, clinical competency, character, fitness to practice medicine, physical and mental condition, ethical or moral standards, or any other matter that may or might directly or indirectly have an effect or bearing on patient care.

14.4 Release

In furtherance of and in the interest of providing quality patient care, each Applicant/Practitioner releases and discharges from loss, liability, cost, damage, and expense, including reasonable attorneys' fees, each UK Party and each third party who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon request of the University or any officer of the Medical Staff, execute a written release in accordance with the tenor and import of this Article.

14.5 Nonexclusivity

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

ARTICLE 15 POLICIES⁸²

15.1 Delegation⁸³

The Organized Medical Staff hereby delegates to the MEC, the authority to the fullest extent possible, to adopt such policies and procedures as may be necessary to implement more

⁸² EP8, EP9 & EP25 MS.01.01.01

⁸³ EP20 MS.01.01.01

specifically the general principles found within these Bylaws. Such policies shall be compliant with these Bylaws. Prior to and after adoption of any such policies and procedures, the MEC shall so notify the Medical Staff and provide a copy of the proposed or adopted policy or procedure.

15.2 Adoption of Policies by Organized Medical Staff

Notwithstanding the above delegation, the Organized Medical Staff may adopt policies and amendments to policies in accordance with the procedures described in ARTICLE 13, above, and may propose policies directly to the University Health Care Committee.

15.3 Urgent Amendments

In cases of a documented need for an urgent amendment to policies necessary to comply with law or regulation, the MEC may provisionally adopt and the University Health Care Committee may provisionally approve an urgent amendment without prior notification to the Medical Staff. In such cases, the Organized Medical Staff will be immediately notified by the MEC. The Organized Medical Staff will then have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Organized Medical Staff and the MEC, the provisional amendment will stand. If there is conflict over the provisional amendment, the matter will be submitted to the Joint Conference Committee for consideration. If necessary, a revised amendment will then be submitted to the University Health Care Committee for action.

ARTICLE 16

NOTICES; CONFIDENTIALITY

16.1 Notices

16.1.1 Notices to Individuals. Any notice to or request from any applicant or individual Medical Staff or Health Professional Staff member required to be given under these Bylaws, shall be deemed to have been properly given to the applicant or individual if in writing and either personally delivered or deposited in the United States certified mail, postpaid, to the address of the applicant or individual on his/her application or to his/her last known address, return receipt requested. Notice so given shall be considered delivered upon the earlier of the date of receipt and three business days after being so deposited in the United States mail.

16.1.2 Notices to the Medical Staff or the Organized Medical Staff. Any notice to the Medical Staff as a whole or the Organized Medical Staff as a whole required to be given by the University, the MEC, the President of the Medical Staff, a Chief Medical Officer, the University Health Care Committee or any other Administration official under these Bylaws or otherwise required by law, regulation or any accreditation standard, shall be deemed to have been properly given if in writing and delivered by email to the email addresses provided by the University to Medical Staff members. Notice so given shall be considered delivered upon being sent.

16.1.3 Notices from Individuals or the Medical Staff. Any notice, request or other communication from an individual or from members of the Medical Staff to the President of the Medical Staff, a Chief Medical Officer or any other officer or Administration

official required to be given under these Bylaws, shall be deemed to have been properly given if in writing and either personally delivered or deposited in the United States certified mail, postpaid, to the attention of such person at 800 Rose Street, Lexington, Kentucky 40536, return receipt requested. Notice so given shall be considered delivered upon the earlier of the date of receipt and three business days after being so deposited in the United States mail.

16.2 Confidentiality of Information

Medical Staff and Medical Staff committee minutes, files and records including information regarding any member or applicant to the Medical Staff or Health Professional Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, in the authorized conduct of Medical Staff proceedings, pursuant to officially adopted UK HealthCare policies, including the authorization of representatives of UK HealthCare and the Medical Staff to solicit and provide information bearing upon a Practitioner's ability and qualifications; or by express approval of the MEC.

ARTICLE 17 AMENDMENTS

17.1 Review and Proposed Amendments⁸⁴

The Bylaws of the Medical Staff of UK HealthCare will be reviewed regularly, at least biennially, by the MEC, which will make recommendations to the Organized Medical Staff and the University Health Care Committee for amendments in accordance with this Article. Members of the Organized Medical Staff may propose amendments to the Bylaws by submitting such proposals to the President of the Medical Staff for consideration at a meeting of the Organized Medical Staff in accordance with Section 13.1.1 or 13.1.2, above. Notice of any proposed amendments including copies thereof will be delivered to the Medical Staff.

17.2 Amendment by the Organized Medical Staff⁸⁵

These Bylaws may be amended by the Organized Medical Staff and the University Health Care Committee. Neither the Organized Medical Staff, nor the University Health Care Committee may unilaterally amend the Bylaws. These Bylaws may be amended after at least 15 calendar days prior written notice has been given to the Organized Medical Staff together with a copy of the proposed amendment, either at the annual meeting or any special meeting of the Organized Medical Staff. To be adopted, an amendment shall require a majority vote of the Organized Medical Staff members attending the Organized Medical Staff meeting at which a quorum is present, including such Organized Medical Staff members who have participated in an electronic vote in accordance with Section 13.4., above.

17.3 Required Approval

Amendments so made shall be effective only when approved by the University Health Care Committee, which has final legal authority. Prior to approval by the University Health Care

⁸⁴ EP24 MS.01.01.01

⁸⁵ EP1 MS.01.01.03

Committee, such committee may request the review and recommendation of the MEC of any amendment approved by the Organized Medical Staff.

17.4 Conflicts⁸⁶

Notwithstanding approval by the Medical Staff and the University Health Care Committee, if these Bylaws shall conflict with the Operating Rules of the University Health Care Committee or the UK Governing or Administrative Regulations, the provisions of the Operating Rules, the UK Governing Regulations and Administrative Regulations shall control.

17.5 Copies of Amendments

Members of the Medical Staff shall be provided with copies of all amendments to these Bylaws or will have access to these Bylaws, including amendments, on the University website.

ARTICLE 18

ADOPTION

These Bylaws shall be adopted upon approval by the Organized Medical Staff as defined in these Bylaws and by the University Health Care Committee and shall, upon such adoption, supersede and replace in their entirety the UK HealthCare Medical Staff Bylaws adopted and approved October 11, 2010, as amended and restated on December 10, 2012, February 18, 2016, December 9, 2019, and June 15, 2023 and any other prior bylaws, rules and regulations adopted by the Medical Staff at UK HealthCare or either Hospital.

Adopted by the Organized Medical Staff: XXX

Approved by the University Health Care Committee: XXX

⁸⁶ EP4 MS.01.01.01