UHCCR 2

Office of the President

June 15, 2023

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.E.2.i establishes the University Health Care Committee to serve as the governing body and authority responsible for managing and operating the University's hospitals and to oversee the University's clinical enterprise 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's hospitals. The Bylaws were adopted and approved on October 11, 2010, and later amended and restated in 2012, 2016, and 2019. Since then, there has been change in UK HealthCare leadership and operations. Therefore, on May 22, 2023, the UK HealthCare Medical Staff (approximately 1,047 members) and the UK HealthCare Medical Staff Executive Committee (22 members) were notified of a special meeting of the Organized Medical Staff (OMS), the voting members of the Medical Staff, on June 6, 2023, 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, and include 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 marked 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 May 22, 2023, the OMS (274 members) was notified of a special meeting on June 6, 2023, to consider this same resolution. The notification included (i) the marked 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 June 9, 2023, the OMS approved the Bylaw amendments as marked in Exhibit 1, and the Medical Staff was notified. The amended Bylaws are 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 below.

Executive Summary

A. Privileging Changed to Every Three Years

The Joint Commission's time frame for evaluating licensed practitioners' ability to provide care, treatment, and services has been updated from every two years to three years, as of Fall of 2022. The proposed amendments change UK's recredentialing cycle from every two years to every three years. The proposed amendments will reduce the workload for the Credentialing Office and is expected to be well-received among UK's licensed practitioners. The proposed amendments contain a corresponding change for members of the Health Professional Staff. (For key provisions, see Article 5 and Article 6).

B. Updates to UK HealthCare Administrative Organization

In 2019, the adopted amendments addressed the new leadership roles of the Chief Physician Executive (CPE), Vice President for Hospital Operations, and Vice President for Ambulatory Services and Medical Group Operations and their relationship with the medical staff. In the proposed amendments, the roles of each of the leaders is further clarified to match current operations.

C. Revisions to Reflect Current Operations in Peer Review

In 2019, the adopted amendments established a peer review framework where peer review is performed to further quality of care under the general oversight of the Peer Review Committee. In the proposed amendments, edits are made to match current operations and clarify the role of the Peer Review Committee in the peer review and remediation process. (For key provisions, see Article 8).

D. Revisions to Reflect Current Terminology

Various edits are being proposed to reflect current Joint Commission terminology and improve consistency throughout the document.

E. Revisions to Reflect Previous Amendments Since 2010

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

Action taken: ☑ Approved ❑ Disapproved ❑ Other_____

UNIVERSITY OF KENTUCKY

UK HEALTHCARE MEDICAL STAFF BYLAWS

ADOPTED AND APPROVED

OCTOBER 11, 2010

AMENDED AND RESTATED

~~**DECEMBER 9, 2019**~~**XXXX**

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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 physicians and dentists 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 Heath 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 Chief Physician Executive, ~~a~~ Chief Medical Officer(s), the Chief Nurse Executive, the Executive Vice President for Health Affairs, the Vice President for Ambulatory Services and Medical Group Operations, the Vice President for Hospital 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.

Children's Hospital
Kentucky Children's Hospital is referred to in these Bylaws as "Children's Hospital" and is the pediatric hospital operated within Chandler Hospital. References in these Bylaws to Chandler Hospital include Children's Hospital.

Chief Clinical Officer[1]
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 ~~in~~ 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)
A Chief Medical Officer is the UK HealthCare officer responsible for oversight activities of the Organized Medical Staff including clinical quality, safety, clinical information services, credentialing, patient care clinical services, outcomes, efficiency, and risk management. A Chief Medical Officer is a member of the Active Medical Staff and is appointed by the Chief Physician Executive, 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 Physician Executive 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, then Chief Medical Officer as used in these Bylaws refers to the Chief Medical Officer appointed by the Chief Physician Executive to perform that duty, responsibility or function. The appointment is administrative and may be removed at any time in the sole discretion of the Chief Physician Executive. The Office of the Chief Medical Officer or "CMO Office" is comprised of Chief Medical Officer(s) and Associate Chief Medical Officers. Chief Medical Officers and Associate Chief Medical Officers ~~each of whom~~ shall be members of the Active Medical Staff appointed by the Chief Physician Executive or by a Chief Medical Officer, subject to the approval of the Chief Physician Executive, who are responsible for delegated functions of the Chief Physician Executive. Each such appointment is administrative and may be removed at any time ~~in~~ at the sole discretion of the Chief Physician

[1] EP4 LD.01.03.01; EP1 & EP5 LD.01.04.01

Executive. The CMO Office also includes the Office of Medical Staff Affairs. A Chief Medical Officer, in addition to duties and responsibilities otherwise described in these Bylaws, shall:

(a) Assist in coordinating the activities of the Administration, the nursing staff, ~~allied health professionals~~ and other non-physician patient care services with those of the Medical Staff, and

(b) As designated by the Chief Physician Executive, serve as an ex-officio member of all Medical Staff committees with vote, except the Peer Review Committee where a Chief Medical Officer as designated by the Chief Physician Executive shall serve as ex-officio member without vote.

Chief Nurse Executive[2]
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 Vice President for Hospital Operations, 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 ~~in~~ at the sole discretion of the Chief Clinical Officer.

Chief Physician Executive
The Chief Physician Executive is responsible for overseeing the clinical practice, Chief Medical Officer(s), CMO Office, clinical quality, and patient safety. The Chief Physician Executive 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 Chief Physician Executive 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.

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

[2] EP5 LD.01.04.01; EP3 NR.01.01.01

recommending action on such packages and requests to the Medical Staff Executive Committee and the University Health Care Committee acting as the governing body.

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 ~~in~~ 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.

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 Executive Committee
The Medical Staff Executive Committee is the executive leadership committee of the Medical Staff.

Medical Staff Operating Subcommittee(s)
The Medical Staff Operating Subcommittees are standing subcommittees of the Medical Staff Executive Committee that are responsible for providing oversight of medical and administrative clinical services, assisting in the monitoring and improvement of patient care, and otherwise fulfilling the responsibilities delegated to them by the Medical Staff Executive Committee. There shall be one Medical Staff Operating Subcommittee for each Hospital: the Chandler Medical Staff Operating Subcommittee and the Good Samaritan Medical Staff Operating Subcommittee.

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

Organized Medical Staff[3]
Organized Medical Staff refers to the members of the Medical Staff in the Active Faculty and Active Community 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 Committee is a standing subcommittee of the Medical Staff Executive Committee that has been delegated the authority to oversee and be responsible for the safety and quality

[3] EP17 MS.01.01.01

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 Practitioner[4]
Licensed practitioner refers to any of a physician, dentist, oral surgeon, physician assistant, nurse practitioner, including certified registered nurse anesthetist, advanced practice registered nurse, certified nurse midwife, and clinical nurse specialist, licensed clinical social worker, clinical psychologist, podiatrist and such other licensed ~~independent~~ 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 ~~or President~~
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 Medical Staff Executive Committee 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 ~~l~~licensed~~n individual~~ 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~~n individual~~ practitioner which affects or could adversely affect ~~adversely~~ 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.

[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."

Third--Party Service
The Third--Party Service is a third--party centralized clinical credentialing service engaged by the University of Kentucky through the CMO 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."

Vice President
Vice President refers to ~~each of~~ the Medical Staff Vice President for Chandler Hospital and the Medical Staff Vice President for Good Samaritan Hospital, who serves as the administrative officer and representative of the Medical Staff for the respective Hospital.

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 ~~in~~ at the sole discretion of the Chief Clinical Officer.

Vice President for Hospital Operations
The Vice President for Hospital Operations 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 ~~in~~ 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]

[5] EP1 MS.03.01.01; EP3 MS.03.01.01

[6] EP4 MS.03.01.01; EP1 MS.05.01.01

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.

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, ~~and~~ 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 Medical Staff Executive Committee, Administration and the University Health Care Committee;

[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

[12] MS.01.01.01

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 granted clinical privileges without Medical Staff membership or appointment.

3.2 Qualifications for Membership[13]

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

[13] EP1 MS.07.01.01

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 ~~that is not limited to a training program and that is~~ 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, either:

(i) have completed a residency program approved by the ACGME or the American Osteopathic Association in the specialty area in which clinical privileges are being sought, and either be board certified in that specialty (by the specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association) or become certified within the period following completion of residency as required by the specialty board, and maintain and document periodic recertification if required by the specialty board, or

(ii) if a physician on the Medical Staff who is a full-time or part-time faculty member of the University of Kentucky, have documented experience equivalent to completion of residency/fellowship and obtaining board certification and have been granted special exemption from the board certification requirement by the Medical Staff Executive Committee upon written request and recommendation of the faculty member's Chair; and

(f) 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

[14] EP2 MS.07.01.01

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, 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 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

[15] EP3 MS.06.01.07; EP4 MS.07.01.01

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 ~~individual~~ 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 ~~individual~~ 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 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;

[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

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 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;

[18] EP5 MS.01.01.01

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 Chief Physician Executive, 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 Chief Physician Executive, 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 Medical Staff Operating Subcommittee, the Medical Staff Executive Committee, 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 Categories[20]

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

4.2 Faculty Appointment[21]

Members of the Medical Staff in the Active Faculty, Associate, 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 Active Community, Courtesy or Honorary categories are not required to be appointed to the faculty of the University.

4.3 Primary Practice Site; Main Provider Clinical Privileges[22]

Each member of the Medical Staff shall, as between the Hospitals, have a primary practice site which shall be designated on the Practitioner's application for appointment, reappointment or clinical privileges. Subject to the restrictions on primary practice site and any limitations on level of clinical privileges indicated below in the description of Medical Staff categories, any Practitioner whose primary practice site is Good Samaritan Hospital must also apply for, obtain and maintain clinical privileges at Chandler Hospital, the main provider. If clinical privileges at either Chandler Hospital or Good Samaritan Hospital are terminated, suspended or restricted in any manner, clinical privileges at the other Hospital shall automatically be terminated, suspended or restricted in the same manner, without right to an additional hearing or appeal.

4.4 Organized Medical Staff[23]

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

(a) A Chief Medical Officer and each Associate and Assistant Chief Medical Officer;

[20] EP12 MS.01.01.01

[21] EP13 MS.01.01.01

[22] EP13 MS.01.01.01

[23] EP17 MS.01.01.01

(b) All Chairs;

(c) Each medical director appointed by a Chief Medical Officer 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;

(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 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;

(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.

4.4.2 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.

4.5 Active Faculty[24]

The Active Faculty category shall be comprised of physicians and dentists who are full-time 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. The primary practice site of an Active Faculty member may be either Hospital. 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.

[24] EP15 MS.01.01.01

4.6 Active Community[25]

The Active Community category shall be comprised of physicians and dentists who are not 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. Physicians who are assigned to work at Good Samaritan Hospital but are not faculty members of either the UK College of Medicine, Dentistry or Public Health, including University-employed, full--time staff physicians, are included in this category. The primary practice site of an Active Community member shall be Good Samaritan Hospital. 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 at Chandler Hospital and may be granted emergency clinical privileges at Chandler Hospital in accordance with Section 7.7.9, below. Active Community members shall have 30 or more Patient Encounters at Good Samaritan Hospital during each 12-month period during the term of their appointment or reappointment measured from the first of the month immediately following the date of appointment or reappointment. If the contract with the University of a Practitioner providing contractual clinical services on an exclusive basis at Good Samaritan Hospital terminates for any reason, the Practitioner's Medical Staff appointment and clinical privileges automatically will terminate, without a hearing or appeal. Clinical privileges shall be delineated upon appointment and with each reappointment. Members of the Active Community 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 Community member is a member of the Organized Medical Staff defined above, however, the member does not have the right to vote.

4.7 Associate[26]

The Associate category shall be comprised of physicians and dentists who are part-time 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 as contributing to the programs of the University. The primary practice site of an Associate member may be either Hospital. Clinical privileges shall be delineated upon appointment and with each reappointment. Members of the Associate 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.

4.8 Courtesy[27]

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. The primary practice site of a Courtesy staff member shall

[25] EP15 MS.01.01.01

[26] EP15 MS.01.01.01

[27] EP15 MS.01.01.01

be Good Samaritan Hospital. 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 at Chandler Hospital and may be granted emergency clinical privileges at Chandler Hospital in accordance with Section 7.7.9, below. Courtesy members shall have fewer than 30 Patient Encounters at Good Samaritan Hospital during any consecutive four calendar quarters. However, Courtesy members shall have a sufficient number of Patient Encounters at Good Samaritan Hospital 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 at Good Samaritan Hospital 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 shall be required to provide emergency service and call coverage and participate on consultation panels on substantially the same basis as Active Community members. 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.

4.9 University Health[28]

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 and employee health services to UK employees and have been endorsed by the Chief Clinical Officer as having competence in their area of practice. The primary practice site of a University Health member will be Chandler Hospital. 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.

4.10 Voluntary[29]

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. The primary practice site of a Voluntary member shall be the Hospital where the teaching program to which he or she contributes is located. Clinical privileges shall be delineated upon appointment and with each reappointment and shall be consistent with the

[28] EP15 MS.01.01.01

[29] EP15 MS.01.01.01

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.

4.11 Clinical Fellow[30]

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.

4.12 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 Medical Staff Executive Committee, 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.

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, of Active Community members, 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 corrective action 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.

[30] EP15 MS.01.01.01

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 Process[31]

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 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 ~~two~~ three years.

[31] EP26 MS.01.01.01

5.5 Medical History and Physical Examination[32]

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 REAPPOINTMENT[33]

6.1 General[34]

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 Medical Staff Executive Committee 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.

6.2 Appointment

6.2.1 Application for Membership[35]

(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

[32] EP16 MS.01.01.01; EP9 MS.03.01.01

[33] 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

[34] EP2 MS.06.01.07

[35] EP2, EP3 & EP9 MS.06.01.05; EP5 MS.06.01.07

specialty board certification, post-graduate training, past and present licenses to practice, and DEA registration;[36]

(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;[37]

(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;

(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;

[36] EP1 MS.06.01.05

[37] EP8 MS.06.01.05; EP1 MS.07.01.03

(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;[38]

(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;[39] 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;[40]

(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

(vi) The applicant will have and continuously maintain professional liability insurance covering acts and occurrences involving professional activities

[38] EP5 MS.06.01.03

[39] EP3 MS.08.01.03

[40] EP6 MS.06.01.05

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 Chief Physician Executive, the Medical Staff Executive Committee, 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 CMO 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 faculty and UK employee applicants, the applicant shall submit his/her application to the Chair of the department in which a primary appointment is sought. For all non--faculty and non--UK employee applicants, the applicant shall submit his/her application either to the CMO Office or to the Third--Party Service.

6.2.5 Department Review for Faculty and UK Employees.[41] 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 CMO Office together with all such opinions and recommendations, including that of the Chair.

6.2.6 Credential Verification.[42] Upon receipt of an application, the CMO 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

[41] EP2 MS.06.01.03; EP6 MS.06.01.07

[42] EP6 MS.06.01.03; EP7 MS.06.01.05; EP3 MS.06.01.13

the Medical Staff. The CMO Office or Third--Party Service shall consult primary sources of information about the Practitioner's credentials, where feasible. The CMO 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 CMO Office or Third--Party Service by all reference sources.

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 CMO 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 CMO Office.

6.2.8 Meeting. The CMO 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 CMO Office or the Chair, a meeting among the applicant, the Chair, and such other persons as may be designated by the CMO 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(s and chiefs), have been collected, received, and verified. The CMO Office, upon completion of the application, shall submit the application, supporting materials, the reports, opinions and recommendations of the Chair(s and chiefs), 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.[43] As promptly as practicable after the Credentials Committee receives the application package from the CMO Office, the Credentials Committee shall:

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

[43] EP10 MS.06.01.05; EP1 & EP2 MS.06.01.01

(b) 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.

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 6.2.10(a) and 6.2.10(b), above, 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 Vice President for Hospital Operations, 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 Medical Staff Executive Committee 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 7.7.1, 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 Medical Staff Executive Committee 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. Between regular meetings of the Medical Staff Executive Committee, reports and recommendations of the Credentials Committee shall be submitted to the Medical Staff Operating Subcommittees which hereby have the delegated authority to 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. References in these Bylaws to the recommendation of the Medical Staff Executive Committee include a recommendation by the Medical Staff Operating Subcommittees acting under this delegation of authority. 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee is a~~d~~verse 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 Committee[44]

(a) At its next regular meeting after receipt of a favorable recommendation of the Medical Staff Executive Committee, 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 Medical Staff Executive Committee, the University Health Care Committee shall submit the matter to the conflict management committee as

[44] EP8 MS.06.01.07; EP2 MS.06.01.09

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 Medical Staff Executive Committee, to the Chair, and to the applicant.[45]

(d) Privileges are granted for a period not to exceed ~~two~~ three years.[46]

6.2.13 Timely Processing of Application.[47] Application for Medical Staff appointment shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. Final action shall be taken 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 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 Medical Staff Executive Committee 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:

[45] EP1, EP3 & EP4 MS.06.01.09

[46] EP9 MS.06.01.07

[47] EP11 MS.06.01.05; EP4 -MS.06.01.07

(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,

~~(e)~~(d) 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

6.4.1 Upon the recommendation by the Medical Staff Executive Committee, and after approval of an applicant's application by the University Health Care Committee (which shall not be bound by the Medical Staff Executive Committee'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 Medical Staff Executive Committee 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.

6.4.2 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 Medical Staff Executive Committee and the Peer Review Committee.[48]

6.4.3 A decision to extend the period of Provisional membership or provisional clinical privileges by the Chair or Medical Staff Executive Committee 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

[48] EP1 MS.08.01.01

Plan. The Provisional member may, however, request further consideration of the Medical Staff Executive Committee. If the decision of the Medical Staff Executive Committee is adverse following further consideration, the Provisional member shall be entitled to the procedural rights provided in the Fair Hearing Plan.

6.4.4 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, Associate, 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 CMO Office, who will submit the information to the Medical Staff Executive Committee and University Health Care Committee.

6.5 Reappointments

6.5.1 The CMO 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.

6.5.2 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 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.[49]

(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 ~~two~~ three years.

6.6 Other

6.6.1 Modifications of Category, Assignment, Clinical Privileges[50]

(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 Medical Staff Executive Committee, 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

(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 CMO Office or the Third--Party Service shall

[49] EP2, EP3 & EP4 MS.07.01.03

[50] EP12 MS.06.01.05

verify the timely renewal of licensure, DEA registration and malpractice insurance upon expiration.[51]

ARTICLE 7
CLINICAL PRIVILEGES[52]

7.1 Exercise of Clinical Privileges[53]

Except as otherwise provided in these Bylaws, a Medical Staff member with clinical privileges at a particular Hospital shall have access to that Hospital to exercise only those clinical privileges specifically granted. 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.[54] 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.

[51] EP6 MS.06.01.03

[52] EP14 MS.01.01.01

[53] EP2 MS.03.01.01

[54] 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 Medical Staff Executive Committee 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.[55] 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.[56]

7.4.5 A Health Professional Staff member may exercise only those clinical privileges specifically granted by the Credentials Committee and the Medical Staff Executive Committee 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

[55] EP1 MS.03.01.03

[56] EP3 MS.03.01.03

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 Medical Staff member will be provided.

7.5 Focused Review of Clinical Privileges[57]

7.5.1 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. ~~However~~T~~,~~ ~~t~~he results of a focused review may lead to collegial intervention, voluntary remediation and/or corrective action, where warranted.

7.5.2 A focused review may be initiated under circumstances when a Practitioner's clinical performance, including but not limited to current competence, clinical skill, technique or judgment, clinical behavior or ability to perform a specific clinical privilege, is called into question, because of a single incident or evidence of a trend based on outcomes, mortality, morbidity, or other concerns and questions or when a Practitioner requests a specific privilege without documented evidence of competence in such privilege. A focused review shall be conducted for each initial request for privilege, each provisionally granted privilege and each change in delineation of privilege.[58]

7.5.3 Focused reviews may be initiated and conducted ~~on~~ at the clinical service level. Focused reviews also may be initiated and conducted by the CMO Office, the Credentials Committee, the Medical Staff Executive Committee, the Peer Review Committee as discussed in ARTICLE 8, or by an ad hoc committee appointed by the Medical Staff Executive Committee. The Medical Staff Executive Committee delegates to the Peer Review Committee the responsibility and authority to develop criteria for conducting focused evaluations of members of the Medical Staff and the Health Professional Staff including, but not limited to, the method for establishing a monitoring plan specific to a requested privilege, the method for determining the duration of performance monitoring, the type of monitoring, the measures to be employed to resolve performance issues and the circumstances under which monitoring by an external source is required. Monitoring may include concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Although the Peer Review Committee shall

[57] EP2, EP3, EP4, MS.08.01.01

[58] EP1, EP5 & EP6 MS.08.01.01

have general authority with respect to establishing and monitoring clinical peer review measures, the Medical Staff Executive Committee may delegate to the Credentials Committee such authority to establish clinical criteria and measures consistent with its responsibility for recommending initial appointments, reappointments and clinical privileges.[59]

7.5.4 The Chair, a Chief Medical Officer, the President of the Medical Staff, the Credentials Committee, the Peer Review Committee or the Medical Staff Executive Committee, as appropriate, will notify the Practitioner that a focused review is being conducted. The Practitioner will be invited and encouraged to participate actively. Because the emphasis is on education and improvement, cooperation by the Practitioner is imperative. If the Practitioner is uncooperative, a focused review may be terminated, and a request for voluntary remediation and/or investigation that could lead to corrective action may be made.

7.5.5 A focused review should be conducted promptly, but thoroughly. Generally, a focused review should be completed within 90 ~~45~~ calendar days, but it may be extended longer, on a case-by-case basis, when appropriate. A focused review for a provisionally granted privilege should be completed within 120 calendar days.

7.5.6 Upon conclusion of the focused review, a finding and recommendation will be made that the Practitioner's performance is acceptable, or that appropriate improvement activities are indicated. The recommendation ~~, which~~ may include, without limitation, further education, clinical "hands-on" training, monitoring, periodic meetings, second opinions, or other efforts to improve performance, reduce morbidity, mortality, errors and enhance quality care and clinical outcomes. The findings and recommendations will be included in a written report that will go to the Medical Staff Executive Committee, the Chair, the CMO Office, the Peer Review Committee and the Credentials Committee. If the recommended improvement activity would constitute a Professional Review Action, then the findings and recommendation shall be submitted to the Medical Staff Executive Committee for action under Section 8.5.5, below.

7.5.7 A focused review is a quality improvement and peer review activity, as discussed in ARTICLE 8. Focused reviews performed under the authority of these Bylaws are designated professional review functions under KRS § 311.377. All information created or gathered through a focused review is confidential and privileged to the fullest extent permitted by law and shall be maintained as confidential under UK HealthCare. All Practitioners are prohibited from disclosing, either orally or in writing, any data, documentation, or reports from a focused review unless authorized by Medical Staff leadership or required by applicable law. The results of a focused review, however, may be considered in making recommendations regarding the continuation, limitation or revocation of any existing clinical privilege.

7.5.8 Focused reviews performed under authority of these Bylaws constitutes a Professional Review Activity for the purpose of furthering quality health care, 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

[59] EP3, EP7, EP8 & EP9 MS.08.01.01

furtherance of the Professional Review Activity to the fullest extent of the law, including the HCQIA and KRS § 311.377.

7.6 Ongoing Professional Practice Evaluation[60]

7.6.1 UK HealthCare uses ongoing professional practice evaluation to identify professional practice trends that might affect the quality of care and patient safety. Identified trends may require intervention by the Organized Medical Staff through the Chair, a Chief Medical Officer, the Chief Physician Executive, the Chief Clinical Officer, the Peer Review Committee or the Medical Staff Executive Committee. The criteria used in ongoing professional practice evaluation may include, but not be limited to, review of operative and other clinical procedures performed and their outcomes, blood and pharmaceutical usage, requests for test and procedures, length of stay patterns, morbidity and mortality data, use of consultants and other criteria. The process for ongoing professional practice evaluation shall be defined by the Peer Review Committee and approved by the Medical Staff Executive Committee. The determination of the type of data to be collected is hereby delegated to the Peer Review Committee subject to the approval of the Medical Staff Executive Committee. Individual departments may supplement such data as may be appropriate for evaluation of Practitioners within such department. Although the Peer Review Committee shall have general authority with respect to establishing and monitoring clinical peer review measures, the Medical Staff Executive Committee may delegate to the Credentials Committee such authority to establish clinical criteria and measures consistent with its responsibility for recommending initial appointments, reappointments and clinical privileges. Information resulting from the ongoing professional practice evaluation will be considered in making recommendations regarding the continuation, limitation or revocation of any existing clinical privilege.

7.6.2 Ongoing professional practice evaluation is a quality improvement and peer review activity, as discussed in ARTICLE 8 further. Ongoing professional practice evaluation performed under the authority of these Bylaws is a designated professional review function under KRS §311.377. All information created or gathered through ongoing professional practice evaluation is confidential and privileged to the fullest extent permitted by law and shall be maintained as confidential under UK HealthCare. All Practitioners are prohibited from disclosing, either orally or in writing, any data, documentation, or reports from ongoing professional practice evaluation unless authorized by Medical Staff leadership or required by applicable law. The results of ongoing professional practice evaluation, however, may be considered in making recommendations regarding the continuation, limitation or revocation of any existing clinical privilege, including administrative action.

7.6.3 Ongoing professional practice evaluation performed under authority of these Bylaws constitutes a Professional Review Activity for the purpose of furthering quality health care, 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

[60] EP1, EP2 & EP3 MS.08.01.03

good faith in furtherance of the Professional Review Activity to the fullest extent of the law, including the HCQIA and KRS § 311.377.

7.7 Temporary Clinical Privileges[61]

7.7.1 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 Medical Staff Executive Committee 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 Chief Physician Executive ~~the Vice President for Hospital Operations,~~ 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 Vice President for Hospital Operations and the applicant of the specific temporary clinical privileges granted and their duration.

7.7.2 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 CMO 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.

[61] EP1, EP2, EP3, EP4, EP5 & EP6 MS.06.01.13; MS-.06.01.11

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 credentialing members or prospective members seeking permanent clinical privileges.[62]

7.7.3 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.

7.7.4 Temporary clinical privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Chief Clinical Officer, ~~the Vice President for Hospital Operations,~~ the Chief Physician Executive, a Chief Medical Officer, the President of the Medical Staff, or the Medical Staff Executive Committee.

7.7.5 Temporary clinical privileges may be immediately terminated at any time by the Chief Clinical Officer, ~~the Vice President for Hospital Operations,~~ the Chief Physician Executive, a Chief Medical Officer or the President of the Medical Staff, who first shall notify the Chair and the CMO 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.

7.7.6 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.

7.7.7 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.

7.7.8 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 Associate, Courtesy or Volunteer 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

[62] EP6, MS-.06.01.13

accepted quality standards and recommended by a Medical Staff member as being appropriate for delivery via telemedicine.[63]

7.7.9 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, 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 Privileges[64]

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

[63] EP1 & EP2 MS.-13.01.03

[64] EP1, EP2, EP3, EP4, EP5, EP6, EP7, EP8 & EP9 EM.02.02.13

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 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 Medical Staff Executive Committee for its review and action.

ARTICLE 8 PEER REVIEW ACTIVITIES

8.1 General

8.1.1 UK HealthCare Medical Staff is committed to improving the delivery of health care by evaluating the professional practice and clinical performance of its Practitioners. Peer review is a supportive activity that is confidential to the fullest extent of the law, including the HCQIA and KRS § 311.377. Peer review is performed to further the quality of care and may involve monitoring, assessment, review, and evaluation of 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. All Practitioners shall cooperate with any peer review activity. All peer review shall be conducted under the general authority of the Peer Review Committee.

8.1.2 All ~~individuals~~ employees are expected to report any concern regarding a Practitioner that affects, or may affect, the safe delivery of quality care.

(a) Concerns that may warrant peer review of a Practitioner may include, but are not limited to, competency, proficiency, behavior, health concerns of a Practitioner, and any conduct that violates the Governance Documents.

(b) Concerns should be communicated to any one (1), but not limited to one (1), of the following persons or organizational units, who shall forward the notice to a Chief Medical Officer:

(i) The Practitioner's Chair,

(ii) The Chief Clinical Officer,

(iii) The President or Vice President of the Medical Staff ~~or Vice President~~,

(iv) The Vice President for Hospital Operations,

(v) The Chief Physician Executive,

(vi) A Chief Medical Officer,

(vii) The CMO Office,

(viii) The Office of Medical Staff Affairs, or

(ix) The Peer Review Committee.

(c) No individual who communicates a concern regarding a Practitioner in good faith shall be subjected to retaliation for communicating the concern. A Practitioner who is found to have retaliated against an individual for communicating a concern shall be subject to corrective action.

(d) Any concern regarding a Practitioner deemed credible by an organizational unit or Medical Staff or Hospital leadership may be the subject of peer review. Any organizational unit of the Medical Staff may perform peer review subject to the review and oversight ~~of~~ by the Peer Review Committee. Upon the consent of the Peer Review Committee, or its designee, an organizational unit may engage consultants, reviewers, medical practitioners, counselors, therapists, or monitors to assist in the performance of peer review.

8.1.3 Peer review may be undertaken:

(a) To evaluate clinical competency, including, but not limited to, focused reviews, conducted under Section 7.5, and ongoing professional practice evaluations,

(b) To elevate clinical performance and enhance the clinical practice environment and University's clinical enterprise,

(c) To evaluate and/or improve patient safety, quality and systems of care,

(d) As part of quality assurance or performance improvement activities,

(e) To maintain the requirements of, and standards set by, these Bylaws,

(f) To address complaints, issues, concerns regarding the Practitioner's clinical competency, conduct, behavior, including disruptive behavior, or health concerns,

(g) To identify, monitor and resolve system issues, or

(h) For any other appropriate purpose~~.~~, including violations of Governance Documents.

8.1.4 Immunity for Peer Review Activities. Peer review performed under authority of these Bylaws constitutes a Professional Review Activity for the purpose of furthering quality health care, 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 the HCQIA and KRS § 311.377.

8.1.5 Peer Review Is Confidential and Privileged. Peer review activities performed under the authority of these Bylaws are designated professional review functions under KRS §311.377. All information created or gathered through a peer review activity is confidential and privileged to the fullest extent permitted by law. All Practitioners are prohibited from disclosing, either orally or in writing, any data, documentation, or reports from a peer review activity unless authorized by Medical Staff leadership or required by applicable law. To the extent possible, documents from peer review activities shall be marked "Confidential Peer Review Document."

8.1.6 Reporting to the Peer Review Committee. Any organizational unit that performs peer review under these Bylaws shall report or make available the results of its peer review activities to the Peer Review Committee.

(a) The conclusion of peer review by an organizational unit should result in one of the following recommendations:

(i) No Action Recommended,

(ii) Collegial Intervention,

(iii) Voluntary Remediation,

(iv) Practitioner Assistance, or

(v) Corrective Action.

(b) An organizational unit that recommends either No Action Recommended or Collegial Intervention may proceed according to its recommendation unless the Peer Review Committee directs otherwise.

(c) An organizational unit that recommends Voluntary Remediation, Practitioner Assistance, or Corrective Action shall report and refer the recommendation to the Peer Review Committee for completion.

8.2 Collegial Intervention

8.2.1 Peer review may result in a recommendation for Collegial Intervention. Collegial Intervention permits Medical Staff leadership, or its designees, to engage a Practitioner in a voluntary, non-adversarial, and informal manner to address concerns or opportunities for improvement. Collegial Intervention is a preferred method for resolving concerns with a Practitioner, but is discretionary and based upon the circumstances under review. Collegial Intervention is voluntary and non-punitive. A Practitioner does not have a right under the Fair Hearing Plan to challenge or appeal a recommendation of Collegial Intervention.

8.2.2 Collegial Intervention may take many forms, including, but not limited to, the following:

(a) Leadership engagement through mentoring or coaching,

(b) Informational or educational letters,

(c) Informal meetings with Medical Staff or Administration,

(d) Education, training, psychiatric or medical evaluation, counseling, treatment, or therapy, or

(e) Any other appropriate solution or resolution voluntarily agreed to by the involved Practitioner.

8.2.3 Collegial Intervention is not a mandatory first step or pre-requisite to any other recommendation, including Corrective Action.

8.3 Voluntary Remediation

8.3.1 Peer review may result in a recommendation for Voluntary Remediation. Voluntary Remediation permits Medical Staff leadership, or its designees, to engage a Practitioner in a voluntary, non-adversarial, and informal manner to address concerns or opportunities for improvement through an agreed upon remedial action plan. Voluntary Remediation is voluntary and non-punitive. Voluntary Remediation requires the willing participation and cooperation of the involved Practitioner to remedy the identified concern.

8.3.2 The Chief Clinical Officer, a Chief Medical Officer, the Chief Physician Executive, the President or Vice President of the Medical Staff ~~or Vice President~~, the Peer Review Committee, or the Chair may initiate Voluntary Remediation to resolve concerns with a Practitioner.

8.3.3 Voluntary Remediation may take many forms, including, but not limited to, the following:

(a) Voluntary relinquishment of clinical privileges,

(b) Leadership engagement through mentoring or coaching,

(c) Informational or educational letters,

(d) Informal meetings with Medical Staff or Administration,

(e) Education, training, psychiatric or medical evaluation, counseling, treatment, or therapy, or

(f) Any other appropriate solution or resolution voluntarily agreed to by the involved Practitioner.

8.3.4 Voluntary Remediation ~~shall~~ may result in an agreement signed by the Practitioner, the Chair, ~~the Chief Physician Executive and a Chief Medical Officer~~and a delegee of the Peer Review Committee that documents a remedial action plan that describes the terms which the Practitioner must satisfy to remedy the concern. The Voluntary Remediation agreement is submitted to the Peer Review Committee and the Chief Physician Executive. A Voluntary Remediation agreement shall include:

(a) The Practitioner's agreement to voluntarily waive any right under the Fair Hearing Plan that might otherwise be available under the Bylaws, and

(b) Terms for corrective action to be taken against the Practitioner in the event the Practitioner does not comply with the remedial action plan.

8.3.5 A copy of the Voluntary Remediation agreement shall be maintained in the Peer Review Office ~~Office of Medical Staff Affairs~~ marked "Confidential Peer Review Document," and shall not be disclosed to any third party without written authorization by Medical Staff leadership or as required by applicable law.

8.3.6 Voluntary Remediation shall constitute a Professional Review Activity for the purpose of furthering quality health care, as described by the HCQIA. If the remedial action plan results in a reduction, restriction, suspension, revocation, denial, or failure to renew clinical privileges or membership on the Medical Staff extending for more than 30 calendar days, the circumstances may be deemed a reportable Professional Review Action, notwithstanding the waiver of rights under the Fair Hearing Plan.

8.3.7 Voluntary Remediation is not a mandatory first step or pre-requisite to any other recommendation, including Corrective Action.

8.4 Practitioner Assistance

8.4.1 Peer review may result in a recommendation for Practitioner Assistance if a Practitioner is impaired due to alcohol use, substance use, or physical or mental illness. The intent of Practitioner Assistance is to preserve the safety and quality of health care delivery, while also addressing a Practitioner's need for treatment in a confidential manner. Actions taken under these Bylaws must be in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act.

8.4.2 UK HealthCare and the Medical Staff, through adoption of policy and other appropriate efforts, shall provide education for members of the Medical Staff, the Health Professional Staff and other Hospital staff about illness and impairment recognition issues specific to licensed independent Practitioners, including at-risk criteria.

8.4.3 An individual that suspects that a Practitioner is impaired shall immediately report the suspicion to the Chief Physician Executive, the Peer Review Committee, or a Chief Medical Officer or designee. The report should be in writing and include the name of the Practitioner suspected of impairment, a detailed account of the facts giving rise to the

suspicion, a list of other persons having information about the suspected impairment and the name of the person making the report. The report, including the name of the person making the report, will be handled in a confidential manner, except as limited by applicable law or ethical obligation, or when the health or safety of a patient is threatened.

8.4.4 The Chief Physician Executive, the Peer Review Committee, or a Chief Medical Officer or designee shall make a reasonable effort to determine whether the suspicion is credible.

8.4.5 If the Chief Physician Executive, the Peer Review Committee, or a Chief Medical Officer concludes that the suspicion of impairment is credible, a Chief Medical Officer shall:

(a) Take appropriate action to stop or prevent any threat to the health or safety of a patient; and

(b) Make a report to the appropriate licensure board and related impairment programs of Practitioner as may be required by law.

8.4.6 Practitioners are strongly encouraged to self-report impairment to the CMO Office and the appropriate licensing board. With self-referral, treatment and management of the condition leading to impairment can occur sooner. UK HealthCare will provide reasonable assistance to facilitate the referral, treatment and management process for an impaired Practitioner. All self-referrals will be handled in a confidential manner except as limited by applicable law or ethical obligation, or when the health or safety of a patient is threatened.

8.4.7 Pending evaluation, assessment, and, if warranted, treatment (e.g., through the Kentucky Physicians Health Foundation), a Chief Medical Officer, the Chief Physician Executive, the Peer Review Committee, the President or Vice President of the Medical Staff ~~or Vice President~~ or the Practitioner suspected of impairment may request Voluntary Remediation. A Voluntary Remediation agreement shall include:

(a) The Practitioner's agreement to exercise clinical privileges subject to monitoring until rehabilitation is complete, and if required, periodically thereafter; and

(b) The Practitioner's agreement to submit to alcohol or drug screening, if appropriate to the impairment, under such terms as required by the Chair, the Chief Physician Executive, or a Chief Medical Officer or designee.

8.4.8 Practitioner Assistance is not a mandatory first step or pre-requisite to any other recommendation, including Corrective Action.

8.5 Corrective Action[65]

8.5.1 Peer review may result in a recommendation for Corrective Action. Corrective Action may be warranted when a Practitioner's activities or conduct pose a substantial risk to patient safety or quality of care, damages professional integrity, or disrupts the orderly hospital operations, including:

(a) Clinical deficiencies, including the failure to meet the Hospital's standards of quality care or applicable professional standards, which may be considered in terms of frequency or severity or both,

(b) Behavior or impairment that is detrimental to patient safety or health care quality, or places the Practitioner or others at a risk of harm, including conduct that is disruptive, abusive, threatening, or inappropriate,

(c) Clinical deficiencies, impairment, or behavior that is determined to be recurrent,

(d) Violations of, or non-compliance with, the terms and conditions of any corrective action plan or remedial action plan,

(e) Violations of, or non-compliance with, UK HealthCare policies, UK HealthCare Corporate Compliance Program, Behavioral Standards in Patient Care, Governance Documents or these Bylaws, or

(f) Material and intentional falsifications of a medical record.

8.5.2 All individuals are expected to report activities or conduct that implicates Corrective Action. Reports may be made to the Chair, a Chief Medical Officer, the CMO Office, the President of the Medical Staff, the Chief Clinical Officer, the Chief Physician Executive, the Vice President for Hospital Operations, or the UK HealthCare Office of Corporate Compliance.

8.5.3 Any allegation or recommendation that implicates Corrective Action shall be referred to the Peer Review Committee for review. If the Peer Review Committee determines that the allegation is credible, the Peer Review Committee shall inform the President of the Medical Staff, the Chief Physician Executive and a Chief Medical Officer in writing of the allegations and the basis for determining the allegation is credible and request an investigation. The President of the Medical Staff shall notify the Chief Clinical Officer and keep him/her fully informed of all proceedings and action taken. The President of the Medical Staff shall also notify the Vice President for Hospital Operations and the Chair of the clinical service in which the questioned activities or conduct occurred.[66]

[65] EP30 MS.01.01.01

[66] EP7 MS.02.01.01

8.5.4 Investigation

(a) Depending on the nature of the activities or conduct under review, the President of the Medical Staff and the Chief Physician Executive or designee, shall appoint an ad hoc committee as the "investigation body" to gather information and review the matter. An ad hoc committee shall be comprised of three members of the Medical Staff, which will include the Vice President at the primary practice site of the affected Practitioner and at least one other who is a member of the Active Medical Staff at the primary practice site of the affected Practitioner. The Peer Review Office and Peer Review Committee can provide assistance with the investigation.

(b) The investigation body shall review records and documentary material that are relevant or that could lead to relevant facts, including, but not limited to, medical records, quality assessment data, quality assessment reports, incident reports, complaints, and other reports. The investigation body may consult with counsel for the University of Kentucky, the UK HealthCare Corporate Compliance Office, the Peer Review Committee or third-party resources, reviewers or consultants regarding the investigation. The investigative body shall have access to all Peer Review Committee notes and materials. The investigation body may interview any person with knowledge or information of the matter under review. All interviews shall be confidential.

(c) The investigation body shall request an interview with the Practitioner, which shall be informal and does not constitute a hearing. During the interview, the Practitioner shall have an opportunity to discuss the subject matter under review. The Practitioner may decline to be interviewed.

(d) The investigation body shall make a written report of its investigation to the Medical Staff Executive Committee. The report shall include any information obtained and reviewed by the investigation body. The report may inform the Medical Staff Executive Committee of additional incidents, deficiencies, problems, or other relevant information learned in the course of investigation. The report shall offer an opinion as to whether the evidence from the investigation supports the recommendation for Corrective Action.

(e) The report shall be delivered to the President of the Medical Staff and the Chief Physician Executive or designee within 30 calendar days from the date the Peer Review Committee requested an investigation unless the President of the Medical Staff or the Chief Physician Executive or designee grants an extension of no more than 30 additional calendar days to complete the investigation.

8.5.5 Action on Report[67]

(a) As soon as practical following receipt of the investigation body report, the President of the Medical Staff shall deliver the report to the Medical Staff Executive

[67] EP6 & EP33 MS.01.01.01

Committee in closed session with voting members only in attendance, either at a regular meeting or a special meeting called for such purpose. The Medical Staff Executive Committee shall act upon the report by:

(i) Issuing a formal decision not to take or recommend action,

(ii) Informing the Practitioner of the investigative body's report and engaging Practitioner in Collegial Intervention, Voluntary Remediation, or Practitioner Assistance, or

(iii) Reducing, restricting, suspending, revoking, denying, or not renewing clinical privileges or Medical Staff membership or recommending any such action to the University Health Care Committee. Any such adverse action shall entitle the physician or oral surgeon to the procedural rights afforded by the Fair Hearing Plan, unless otherwise provided in the Fair Hearing Plan or elsewhere in these Bylaws.

8.5.6 Summary Suspension[68]

(a) Whenever a Practitioner willfully disregards these Bylaws or UK HealthCare policies, or whenever his/her conduct may require that immediate action be taken to protect the health or safety of a patient, or to reduce the substantial likelihood of imminent injury to the health or safety of any patient, employee, or other person in the Hospital, the Practitioner's Medical Staff appointment and/or any or all of the Practitioner's clinical privileges may be summarily suspended:

(i) Upon the recommendation of a Chief Medical Officer, approved by the Chief Physician Executive, with the concurrence of the President of the Medical Staff, or

(ii) The Chief Physician Executive, with the concurrence of the President of the Medical Staff.

(b) The summary suspension shall become effective immediately upon imposition. The Chief Physician Executive shall immediately notify the Practitioner, the Chair, a Chief Medical Officer, the Vice President for Hospital Operations and the Medical Staff Executive Committee of the suspension. The Chief Physician Executive, a Chief Medical Officer or the Chair shall arrange alternative medical coverage of the suspended Practitioner's patients in the Hospital. The wishes of the patients shall be considered in the selection of an alternative Practitioner.

(c) Upon summary suspension of a Practitioner, the Medical Staff Executive Committee shall appoint an ad hoc committee from the Medical Staff Executive Committee to investigate the need for the suspension or further action concerning the Practitioner. Within 14 calendar days thereafter, the Medical Staff Executive Committee shall

[68] EP29 & EP32 MS.01.01.01

meet to discuss the findings of the investigation. The Medical Staff Executive Committee may, as a result of the meeting, recommend modification, continuation, or termination of the summary suspension, and may take such further action concerning the Medical Staff membership and clinical privileges of the Practitioner as it considers appropriate. If the investigation is completed within 14 calendar days from the date of the suspension and the investigation does not result in adverse action, as defined in the Fair Hearing Plan, the Practitioner shall not be entitled to the procedural rights of the Fair Hearing Plan. If the Medical Staff Executive Committee does not recommend immediate termination of the suspension or if further adverse action, as defined in the Fair Hearing Plan, is taken as a result of the investigation:

(i) The Practitioner shall be afforded the right to a hearing as provided in the Fair Hearing Plan pursuant to ARTICLE 9 but the terms of the summary suspension or further adverse action recommended by the Medical Staff Executive Committee shall remain in effect pending a final decision under the Fair Hearing Plan.

(ii) The Chief Physician Executive, a Chief Medical Officer or the Chair shall arrange for alternative medical coverage of the suspended Practitioner's patients in the Hospital. The wishes of the patient shall be considered in the selection of an alternative Practitioner.

8.5.7 Recusal. No person shall participate in any peer review activity if it is determined that the person's presence would:

(a) Inhibit the full and fair discussion of the issue,

(b) Skew the recommendation or determination of the Medical Staff Executive Committee, the ad hoc committee or the investigation body, or

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

8.6 Automatic Suspensions[69]

8.6.1 Loss of Licensure or Federal Sanctioning. If a Practitioner's license or other legal credential authorizing him/her to practice is revoked or suspended by a state licensing authority, or the individual has been included on the OIG Sanction Report, the GSA List, or any other Federal or State report of sanctions, he/she shall immediately and automatically be suspended from practicing in the Hospital by the Chief Physician Executive or a Chief Medical Officer, and his/her Medical Staff membership shall automatically be terminated.

8.6.2 Lapse of Liability Insurance. A Practitioner who does not maintain professional liability insurance as required in these Bylaws shall be automatically suspended until he/she furnishes adequate and satisfactory evidence of such coverage without gaps of coverage for all periods of practice.

[69] EP28 MS.01.01.01

8.6.3 Revocation or Suspension of DEA. A Practitioner whose DEA number is revoked or who is suspended from prescribing scheduled drugs as recognized by the DEA shall immediately and automatically be suspended from practicing in the Hospital by the Chief Physician Executive or a Chief Medical Officer and his/her Medical Staff membership shall automatically be terminated. In regard to actions restricting a Practitioner's right to prescribe non-scheduled drugs, the Medical Staff Executive Committee may consider and take such action as it deems necessary, provided, however, that the Chief Physician Executive may take such action as he/she may deem appropriate in accordance with Section 8.5.6, above.

8.6.4 Criminal Action. A Practitioner who is convicted or pleads guilty or *nolo contendere* to any felony or to a misdemeanor involving (i) the practice of such Practitioner's profession, (ii) controlled substances, (iii) illegal drugs, (iv) Medicare, Medicaid, or insurance fraud or abuse, (v) violence against another, or (vi) moral turpitude shall immediately and automatically be suspended from practicing in the Hospital by the Chief Physician Executive or a Chief Medical Officer and his/her Medical Staff membership shall automatically be terminated. Upon indictment or charge for any of the above offenses, the individual shall immediately report such indictment or charge to the Chief Physician Executive or a Chief Medical Officer who shall refer such report to the Medical Staff Executive Committee for investigation and any recommendation or action deemed appropriate. P ~~and p~~ending such investigation, the individual's clinical privileges shall automatically be suspended.

8.6.5 Process for Automatic Suspension.[70] Pursuant to Sections 3.3.19 and 3.3.20 above, the Practitioner shall immediately notify the CMO Office of any circumstances that give rise to automatic suspension of clinical privileges and/or automatic termination of Medical Staff appointment. Immediately upon the occurrence of such circumstances and without notice to the Practitioner, the Practitioner's clinical privileges shall be suspended and/or the Practitioner's Medical Staff appointment shall be terminated, as provided in this Section 8.6. The Chief Physician Executive, a Chief Medical Officer or the Chair shall arrange alternative medical coverage of the suspended or terminated Practitioner's patients in the Hospital. The wishes of the patients shall be considered in the selection of the alternative Practitioner.

8.7 Medical Records

In accordance with UK HealthCare policy, a Practitioner's admitting and consulting clinical privileges shall be automatically suspended at all UK HealthCare facilities, including the Hospitals, if after warning of delinquency, the Practitioner fails to complete medical records in a timely fashion. Medical records include inpatient, outpatient, emergency, observation, and other records. The suspension shall continue until the records are completed, unless the Practitioner satisfies a Chief Medical Officer that he/she has a justifiable excuse for such failure. Timely refers to the time frames set forth in applicable UK HealthCare policies. The suspended Practitioner shall not be afforded the right to a hearing or appeal under the Fair Hearing Plan. The Practitioner shall arrange alternative coverage for patients under his/her care. If the Practitioner fails to provide alternative coverage, the Chief Physician Executive, a Chief Medical

[70] EP31 MS.01.01.01

Officer or the Chair shall arrange for alternative medical coverage of the suspended Practitioner's patients in the Hospital. The wishes of the patient shall be considered in the selection of an alternative Practitioner.

8.8 Automatic Resignation

8.8.1 Unless otherwise designated by a clinical service or approved by the University Health Care Committee upon recommendation of the Medical Staff Executive Committee, any member of the Medical Staff or person with clinical privileges who takes up permanent residence that does not satisfy the requirement under Section 3.2.2, above, to be close enough to the applicable Hospital to permit such member or person to provide continuous care to his/her patients shall be deemed to have resigned from the Medical Staff, and all clinical privileges of such member shall be terminated automatically, without the right to a hearing or appeal under the Fair Hearing Plan.

8.8.2 Any Practitioner who fails to complete and submit his/her credentialing application in a timely fashion shall be deemed to have resigned his/her clinical privileges and Medical Staff appointment effective upon the expiration of the then current term, without the right to a hearing or appeal under the Fair Hearing Plan.

8.9 Report to the National Practitioner Data Bank and Board of Medical Licensure

The President of the Medical Staff or his/her designee shall:

8.9.1 Notify the National Practitioner Data Bank of any Professional Review Action taken which requires reporting under the HCQIA; and

8.9.2 Notify the Kentucky Board of Medical Licensure of any Professional Review Action taken as required by Kentucky law.

ARTICLE 9
FAIR HEARING PLAN[71]

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:

[71] EP34 MS.01.01.01; MS.10.01.01

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 under Section 7.5, above, and an investigation conducted under Section 8.5.4, 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, 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 Medical Staff Executive Committee in respect to 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;

(c) Any corrective action taken by the Medical Staff Executive Committee pursuant to Section 8.5.5, above; or

(d) A summary suspension or adverse action recommended by the Medical Staff Executive Committee following an investigation and meeting pursuant to Section 8.5.6, 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), or 3.2.1(f), 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 Medical Staff Executive Committee 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, and

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

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 Action[72]

9.3.1 When a Professional Review Action is taken giving an Affected 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;

[72] EP2 & EP5 MS.06.01.09

(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 Medical Staff Executive Committee 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 Medical Staff Executive Committee 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 Panel[73]

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.

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

[73] EP35 MS.01.01.01

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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee 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
Preventive Medicine & Environmental Health
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 Medical Staff Executive Committee 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 either provided on an exclusive contractual basis or the Medical Staff Operating Subcommittee of Good Samaritan Hospital determines that there is substantial clinical activity, the Medical Staff Executive Committee 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.

> [E.g., if the Medical Staff Executive Committee 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 Medical Staff Executive Committee 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, the Vice President for Good Samaritan Hospital 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, the Vice President for Good Samaritan Hospital 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. An Active Community member may be appointed as Chief of a Good Samaritan Hospital Clinical Division.

10.2 Assignment to Clinical Services

Each Medical Staff member shall be assigned to one clinical service by the Medical Staff Executive Committee 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee;

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 Medical Staff Executive Committee 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 Service[74]

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 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

[74] EP36 MS.01.01.01

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 ~~personnel~~ staff who are not licensed ~~independent practitioners~~ 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 Vice President for Hospital Operations 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 Medical Staff Executive Committee 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 Terms[75]

The officers of the Medical Staff shall be:

Office	Term
President of the Medical Staff	2 years, no more than 2 terms
Vice President for Chandler Hospital	2 years, no more than 2 terms
Vice President for Good Samaritan Hospital	2 years, no more than 2 terms
Secretary	As appointed by the President of the Medical Staff

11.2 Qualifications of Officers[76]

11.2.1 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 primary practice site of the Vice President for Chandler Hospital shall be Chandler Hospital, and the primary practice site of the Vice President for Good Samaritan Hospital shall be Good Samaritan Hospital. 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.

[75] EP19 MS.01.01.01

[76] EP1 MS.03.01.01

11.3 Nominations and Elections[77]

Biennially, in even numbered years, the Nominating Committee shall prepare a slate of nominees for each of the positions of President and Vice Presidents 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 or for the office of Vice President for a Hospital, by at least 10% of the Active Medical Staff with a primary site of practice as that required for such Vice President, 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 President of the Medical Staff will be elected by a majority vote of the Organized Medical Staff casting ballots. Each Vice President will be elected by a majority vote of the Organized Medical Staff casting ballots whose primary practice site is the same as that required of the particular Vice President. 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 either of the offices of Vice President shall be filled by appointment made by the President of the Medical Staff with Medical Staff Executive Committee approval. A vacancy in the office of President of the Medical Staff shall be filled by appointment by the majority vote of the Medical Staff Executive Committee. Pending such appointment, a Chief Medical Officer shall serve as interim President of the Medical Staff.

11.5 Resignations and Removals[78]

Any officer may resign at any time by giving written notice to the Medical Staff Executive Committee 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee and, upon receipt thereof, a Chief Medical Officer shall call a meeting of the Medical Staff Executive Committee 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 Medical Staff Executive Committee in favor of removal. If an

[77] EP18 MS.01.01.01

[78] EP18 MS.01.01.01

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 Staff.[79] 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 Medical Staff meetings;

(e) Developing and implementing, in conjunction with Chairs, the Chief Physician Executive, 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 Chief Physician Executive, 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 Medical Staff Executive Committee, the Medical Staff Operating Subcommittees 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

[79] EP1 & EP3 MS.03.01.01

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

11.6.2 Vice President for Chandler Hospital. The Vice President for Chandler Hospital shall, in the absence of the President of the Medical Staff fulfill the duties of the President of the Medical Staff as same apply to Chandler Hospital. The Vice President for Chandler Hospital shall chair the Medical Staff Operating Subcommittee at Chandler Hospital. In addition, the Vice President for Chandler Hospital shall perform such duties as may be delegated by the President of the Medical Staff.

11.6.3 Vice President for Good Samaritan Hospital. The Vice President for Good Samaritan Hospital shall, in the absence of the President of the Medical Staff fulfill the duties of the President of the Medical Staff as same apply to Good Samaritan Hospital. The Vice President for Good Samaritan Hospital shall chair the Medical Staff Operating Subcommittee at Good Samaritan Hospital. In addition, the Vice President for Good Samaritan Hospital shall perform such duties as may be delegated by the President of the Medical Staff.

11.6.4 Secretary. The Secretary shall serve as staff to the Medical Staff Executive Committee, 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 Medical Staff Executive Committee, the Medical Staff Operating Subcommittees and Medical Staff meetings, and record attendance.

ARTICLE 12
COMMITTEES AND FUNCTIONS

12.1 Medical Staff Executive Committee[80]

12.1.1 Responsibility and Authority[81]

(a) The Medical Staff Executive Committee 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 Medical Staff Executive Committee 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:

[80] EP20 MS.01.01.01

[81] EP20 & EP23 MS.01.01.01; EP5 MS.02.01.

(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 ~~independent~~ 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 Medical Staff Executive Committee shall receive and act on reports and recommendations from Medical Staff committees, clinical services, and assigned activity groups.[82] The Medical Staff Executive Committee 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);[83]

(ii) The structure of the Organized Medical Staff and the Active Medical Staff;[84]

(iii) The process used to review credentials and delineate privileges;[85]

[82] EP6 & EP12 MS.02.01.01

[83] EP8 MS.02.01.01

[84] EP9 MS.02.01.01

[85] EP10 MS.02.01.01

(iv) The specific delineation of clinical privileges for each ~~eligible Practitioner~~licensed practitioner, based on demonstrated competency and performance review;[86]

(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.[87] The Medical Staff Executive Committee shall consist of the following voting members:

President of the Medical Staff (chair)

Vice President for Chandler Hospital

Vice President for Good Samaritan Hospital

Six other representatives from the Medical Staff Operating Subcommittees each of whom shall be a Chair, divided between the subcommittees pro-rata based on the average daily census of the respective Hospital for the calendar quarter ending March 31 immediately preceding selection, selected biennially in even-numbered years by the membership of each such subcommittee following the average daily census determination.

Three at-large members, including one member of the Active Community or Active Faculty category whose primary site is Good Samaritan Hospital, one member of the Active Faculty category with clinical privileges at Children's Hospital and one member of the Active Faculty category whose primary site is Chandler Hospital and who does not have clinical privileges at Children's Hospital, each elected by the Organized Medical Staff as described in Section 12.1.3, below.[88]

Chief Medical Officer(s) as designated by the Chief Physician Executive

Chair of the Credentials Committee

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

Chief Clinical Officer

Dean, College of Medicine

ACGME Designated Institutional Official or designee [89]

Chief Nurse Executive

[86] EP11 MS.02.01.01

[87] EP22 MS.01.01.01; EP2 & EP4 MS.02.01.01

[88] EP3 MS.02.01.01

[89] EP5 & EP6 MS.04.01.01

Dean, College of Pharmacy or Director of Pharmacy, as his/her designee

Dean, College of Nursing

Dean, College of Dentistry

Legal Counsel for the University

Vice President for Hospital Operations

Vice President for Ambulatory Services and Medical Group Operations

Chief Physician Executive

Chief Information Officer

12.1.3 Nominations.[90] Biennially in even-numbered years, the Nominating Committee shall prepare a slate of nominees for each at-large member of the Medical Staff Executive Committee and for each at-large member of the Medical Staff Operating Subcommittees 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 Medical Staff Executive Committee signed by at least 10% of the appointees of the Active Medical Staff or for at-large members of the Medical Staff Operating Subcommittees, by at least 10% of the Active Medical Staff with a primary site of practice as the subcommittee in question, 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 Medical Staff Executive Committee in each of the three qualifying categories receiving the highest number of votes of the Organized Medical Staff shall be elected to the Medical Staff Executive Committee. The three nominees for at-large membership on each of the Medical Staff Operating Subcommittees receiving the highest number of votes of the Organized Medical Staff whose primary site of practice is the Hospital in question, shall be elected to such Medical Staff Operating Subcommittee.

12.1.4 Meetings. The Medical Staff Executive Committee shall meet as often as necessary to discharge fully its duties and responsibilities in a timely, efficient manner. Minutes of the Medical Staff Executive Committee shall be forwarded to the University Health Care Committee. A majority of members of the Medical Staff Executive Committee 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 Medical Staff Executive Committee. At times appropriate and necessary, the Medical Staff Executive Committee may take action without a meeting by unanimous consent (setting forth the action so taken), provided by each member entitled to vote thereat. 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.

[90] EP21 MS.01.01.01

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

12.1.6 Resignations and Removals.[91] Any member of the Medical Staff Executive Committee 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee and, upon receipt thereof, the President of the Medical Staff shall call a meeting of the Medical Staff Executive Committee 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 majority of the valid votes cast at the meeting of the Medical Staff Executive Committee 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 Medical Staff Operating Subcommittees

12.2.1 Responsibility and Authority. The Medical Staff Operating Subcommittees consist of two standing subcommittees of the Medical Staff Executive Committee, which are responsible for providing oversight of medical and administrative clinical services, assisting in the monitoring and improvement of patient care, and otherwise fulfilling the responsibilities delegated to it by the Medical Staff Executive Committee. There shall be one Medical Staff Operating Subcommittee for each Hospital: Chandler Hospital and Good Samaritan Hospital. The Medical Staff Operating Subcommittees shall meet regularly, at least 10 times per year.

12.2.2 Composition. The voting members of the Medical Staff Operating Subcommittee for each particular Hospital include the President of the Medical Staff, the Vice President for the particular Hospital, a Chief Medical Officer as designated by the Chief Physician Executive, the Chair of the Credentials Committee, the Chairs for each clinical service or their designees, and three at-large members elected by the Organized Medical Staff whose primary site of practice is the particular Hospital. Advisory members who serve ex officio without vote include the Director of Pharmacy, Chief Nurse Executive, Vice President for Hospital Operations, Vice President for Ambulatory Services and Medical Group Operations, Chief Information Officer, ACGME Designated Institutional Official or designee, and legal counsel for the University. A resident representative(s) selected by the House Staff Counsel who has a clinical rotation at the particular Hospital shall also serve without vote on the Medical Staff Operating Subcommittee at such Hospital. Each voting and non-voting member of the Medical Staff Executive Committee may attend any meeting of either Medical Staff Operating Subcommittee. The presence of at least five members of the Medical Staff Operating

[91] EP21 MS.01.01.01

Subcommittee 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 Vice President when a quorum is available and is present. At times appropriate and necessary, the Medical Staff Operating Subcommittee may take action without a meeting by unanimous consent (setting forth the action so taken), provided by each member entitled to vote thereat. 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.

12.2.3 Vacancies. Vacancies on the Medical Staff Operating Subcommittee shall be filled by appointment made by the President of the Medical Staff with Medical Staff Executive Committee approval.

12.2.4 Resignations and Removals. Any member of the Medical Staff Operating Subcommittee 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 Medical Staff Executive Committee 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 Medical Staff Executive Committee and, upon receipt thereof, the President of the Medical Staff shall call a meeting of the Medical Staff Executive Committee 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 majority of the valid votes cast at the meeting of the Medical Staff Executive Committee 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.

12.2.5 Relationship with the Medical Staff Executive Committee. Between regular meetings of the Medical Staff Executive Committee, the Medical Staff Operating Subcommittees shall be responsible for fulfilling the duties and obligations of the Medical Staff Executive Committee enumerated in Sections 12.1.1(a) and 12.1.1(b), above, excepting only the enforcement of voluntary remediation, disciplinary, and corrective action, including revocation and termination of membership and clinical privileges which is expressly reserved to the Medical Staff Executive Committee. Without the affirmative vote of at least two-thirds of the voting members of the Medical Staff Executive Committee, the Medical Staff Executive Committee shall not overturn any decision approved by a Medical Staff Operating Subcommittee. Notwithstanding the foregoing, the Medical Staff Executive Committee may resolve a conflict between the Medical Staff Operating Subcommittees by a majority vote of a quorum present at a duly called meeting of the Medical Staff Executive Committee.

12.3 Credentials Committee and Privileging Subcommittee(s)

12.3.1 Responsibility and Authority. The Credentials Committee is a standing subcommittee of the Medical Staff Executive Committee 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 Chief Physician Executive, 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.

12.3.2 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.

12.4 Nominations Committee

12.4.1 The Nominations Committee shall be composed of the President of the Medical Staff, the Vice President for Hospital Operations, the Chief Clinical Officer, the Chief Nurse Executive, a Chief Medical Officer and four 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, for the at-large members of the Medical Staff Executive Committee and for the at-large members of the Medical Staff Operating Subcommittees.

12.5 Joint Conference Committee[92]

12.5.1 Responsibility and Authority. The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, including discussions and, if necessary informal conflict management and resolution, relating to conflict between or among Administration, the Medical Staff Executive Committee and the Medical Staff relative to Medical Staff self-governance or proposals to adopt a rule, regulation, policy or amendment thereto. The Joint Conference Committee shall also serve as a forum for interaction between the University Health Care Committee and the Medical Staff on such other matters as may be referred by the Medical Staff Executive Committee, the University Health Care Committee or at least 20 members of the Organized Medical Staff. The

[92] EP10 MS.01.01.01

Joint Conference Committee shall exercise other responsibilities as set forth in these Bylaws or in UK HealthCare policies.

12.5.2 Composition. The Joint Conference Committee shall be composed of an equal number of the members of the University Health Care Committee, appointed by the chairperson of such committee, and of the Medical Staff Executive Committee, appointed by the President of the Medical Staff, but the Medical Staff Executive Committee members shall include a Chief Medical Officer and at least one at-large member of the Medical Staff Executive Committee. Either the President of the Medical Staff or if the Joint Conference Committee is considering a written request directly from the Organized Medical Staff, up to two members of the Organized Medical Staff designated by the members of the Organized Medical Staff making the request, shall serve on an ad hoc basis on this committee. The Chief Clinical Officer shall also serve on the Joint Conference Committee, ex officio with vote. The appointments are administrative and may be removed at any time by the Chairperson of the University Health Care Committee and the President of the Medical Staff, respectively. The chair of the Joint Conference Committee shall be selected by the members of such committee.

12.5.3 Meetings. The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Medical Staff Executive Committee and to the University Health Care Committee. Meetings may be called by any of the members of the Joint Conference Committee or by written request of at least 20 members of the Organized Medical Staff eligible to vote submitted to the President of the Medical Staff. Notwithstanding any recommendation or report of the Joint Conference Committee, the University Health Care Committee has the ultimate authority and shall make any final decision on any matter referred from the committee.

12.6 Peer Review Committee

12.6.1 Responsibility and Authority. The Peer Committee is a standing subcommittee of the Medical Staff Executive Committee 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.

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

Vice President for Chandler Hospital

Vice President for Good Samaritan Hospital

Chair of the Credentials Committee

Medical Director of Risk Management

Senior Associate Dean of Faculty Affairs

Physician Chair of the UK HealthCare Quality and Safety Committee

Chair of the Practitioner under review

Director of the Office of Advanced Practice

Associate Chief Medical Officer for Patient Safety

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.

Three 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.

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

President of the Medical Staff

A Chief Medical Officer as designated by the Chief Physician Executive

Legal Counsel for the University

UK HealthCare Chief Compliance Officer

Assistant Vice President for Institutional Equity

Director of Risk Management

Other ad hoc personnel as determined by the chair of the Peer Review Committee

12.6.3 Meetings. The presence of at least seven members of the Peer Review Committee entitled to vote, physically 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 (setting forth the action so taken), provided by each member entitled to vote thereat. 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.

12.6.4 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.

12.6.5 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.

12.7 Other Committees

12.7.1 Other standing committees of the Medical Staff are described in this Section. 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 Medical Staff Executive Committee 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 a Chief Medical Officer, subject to the approval of the Medical Staff Executive Committee 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 Chief Physician Executive, a Chief Medical Officer as designated by the Chief Physician Executive, the Chief Clinical Officer or the Vice President for Hospital Operations 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.

12.7.2 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.

12.7.3 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.

12.7.4 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. The chair of the UK HealthCare Quality and Safety Committee shall be the Chief Clinical Officer or designee. The chairperson of the University Health Care Committee may appoint one trustee member of such committee to serve as a member of the UK HealthCare Quality and Safety Committee.

12.7.5 Transfusion Committee. The Transfusion Committee shall review blood usage.

12.7.6 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 Medical Staff Executive Committee.

12.7.7 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.

12.7.8 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 ICU program; and to monitor, document, and continually improve the care provided at the Hospitals. The committee may consult any and 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.

12.7.9 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.

12.7.10 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.

12.7.11 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.

~~12.7.12 Medical Imaging Committee. The Medical Imaging Committee oversees all efforts to optimize clinical appropriateness and appropriate utilization of medical imaging at UK HealthCare. The Medical Imaging Committee is responsible for: (i) evaluating the clinical appropriateness of requested medical imaging and (ii) developing policies and protocols to promote appropriate utilization of medical imaging.~~

~~12.7.13~~12.7.12 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.

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 Medical Staff Executive Committee of any rule, regulation, policy or amendment thereto requested to be considered by the Organized Medical Staff.[93]

13.1.2 Special Meetings. A Chief Medical Officer, the President of the Medical Staff or any Vice President 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 Medical Staff Executive Committee of any rule, regulation, policy or amendment thereto requested to be considered by the Organized Medical Staff.[94]

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

[93] EP9 MS.01.01.01

[94] EP9 MS.01.01.01

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 Conduct of Meetings

If feasible, meetings of the Organized Medical Staff shall be conducted through video teleconference with Chandler Hospital as the primary location and Good Samaritan Hospital as a video teleconference location. Additional video teleconference locations may be added as may be feasible to afford Medical Staff members the opportunity to attend.

13.3 Quorum[95]

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 Medical Staff Executive Committee shall, at its next meeting, act for the Organized Medical Staff on all issues requiring vote.

13.4 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.

13.5 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.

13.6 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.

[95] EP23 MS.01.01.01

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 summary suspensions or revocations 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 summary suspensions or revocations 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
POLICIES[96]

15.1 Delegation[97]

The Organized Medical Staff hereby delegates to the Medical Staff Executive Committee, the authority to the fullest extent possible, to adopt such policies and procedures as may be necessary to implement more 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 Medical Staff Executive Committee shall so notify the Medical Staff and provide a copy of the proposed or adopted policy or procedure.

[96] EP8, EP9 & EP25 MS.01.01.01

[97] EP20 MS.01.01.01

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 Medical Staff Executive Committee 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 Medical Staff Executive Committee. 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee.

ARTICLE 17
AMENDMENTS

17.1 Review and Proposed Amendments[98]

The Bylaws of the Medical Staff of UK HealthCare will be reviewed regularly, at least biennially, by the Medical Staff Executive Committee or the Medical Staff Operating Subcommittees, 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 Staff[99]

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 13.5, above.

[98] EP24 MS.01.01.01

[99] EP1 MS.01.01.03

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

17.4 Conflicts[100]

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, and December 9, 2019, 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: ~~November 14, 2019~~
Approved by the University Health Care Committee: ~~December 9, 2019~~

[100] EP4 MS.01.01.01