MEDICAL STAFF BYLAWS

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Medical Staff Services – (813) 844-8350

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BYLAWS OF THE MEDICAL STAFF OF THE FLORIDA HEALTH SCIENCES CENTER

DEFINITIONS

1. **BOARD** means the Board of Directors of Tampa General Hospital, its governing body.

2. **CHIEF EXECUTIVE OFFICER or CEO** means the individual appointed by the Board of Trustees to act in its behalf in the overall management of the hospital. For the purpose of these rules/regulations, the term "Chief Executive Officers" includes a duly appointed Senior Administrator who has been delegated by the CEO and is serving when the CEO is away from the Hospital. The Medical Staff may rely on all actions of the CEO as being the actions of the Board of Trustees taken pursuant to a proper delegation of authority of the Board of Trustees.

3. **CHIEF MEDICAL OFFICER** is a physician appointed by the Board to oversee medical staff relations.

4. **COLLEGE OF MEDICINE** means the University of South Florida College of Medicine

5. **EXCLUSIVE CONTRACT:** The exclusive contract that an Exclusive Contractor enters into with the hospital to provide one or more hospital services.

6. **EXCLUSIVE CONTRACTOR:** Any medical group or person which enters into a contract with the hospital to provide one or more hospital services.

7. **FULL AND UNRESTRICTED LICENSE TO PRACTICE MEDICINE:** A "clear / active" license to practice medicine, as that term is defined and utilized by the Florida Department of Health's Boards, Councils and Committees

8. **MEDICAL STAFF** means a formal organization of doctors of medicine, doctors of osteopathic medicine, dentists, podiatrists, and psychologists licensed under chapter 458, 459, 461, 466, or 490 of the Florida Statutes, who hold an unrestricted license in this state or practitioners who meet exceptions outlined under 458.303, 455.02, or 458.3145 and who are privileged to manage and coordinate a patient's general medical condition in the hospital within the scope of their licensure and approved clinical privileges, and who have been granted appointment and privileges by the Board of Trustees

9. **NOTICE** is deemed given when a written communication is (a) hand delivered to the practitioner's home or business office address, as indicated by a signature of practitioner or practitioner's office staff member, or (b) sent by any delivery service offered by UPS, FED EX, or other commercial express delivery service to be delivered to the practitioner's home or business office with proof of delivery, or (c) sent by certified or registered mail, return-receipt-requested, to the last home or business office address of the practitioner on file with proof of delivery, or (d) transmitted by facsimile or email to the practitioner's last know home or business fax or email address.

10. **PATIENT ENCOUNTERS:** are considered medical decision-making events that result in documented care on an inpatient or outpatient including, consultations, progress notes, pathology, intra-operative monitoring and radiology reports, surgical and procedure reports for ER visits and Inpatients or office visits at provider-based Outpatient facilities. Provider-based means those facilities that may bill Medicare as a Tampa General Hospital provider-based entity.

11. **PHYSICIAN:** an allopathic physician (M.D.) or osteopathic physician (D.O.).

12. **PROCTOR/PROCTORING:** A Proctor is a practitioner who is competent and privileged to perform the privileges being observed and whose clinical knowledge and expertise qualifies them for evaluating the performance of the proctoree. The proctor's role is that of an assessor and reporter, not a consultant or mentor. Proctoring is a process of direct observation that allows for the objective evaluation of a physician's clinical competence by a proctor who represents, and is responsible to, the medical staff.

NOTE: All pronouns and any variations shall be interpreted to refer to persons of either gender.

ARTICLE I. NAME

The name of this organization shall be the Tampa General Hospital Medical Staff. Tampa General Hospital has an open, diverse and inclusive Medical Staff dedicated to quality patient care, treatment and services.

ARTICLE II. PURPOSES and RESPONSIBILITIES

The purposes and responsibilities of the organized Medical Staff are:

1. To implement the mission and vision of the Florida Health Sciences Center Board.

2. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and function of the Medical Staff.

3. To foster an inclusive environment that recognizes the contributions and supports the advancement of all; regardless of race, ethnicity, national origin, citizenship, religion, gender, age, marital status, socioeconomic status, language, sexual orientation, gender identity, or disability.

4. To accept responsibility for oversight of the quality of medical care and the process of analyzing and improving patient satisfaction, patient safety, treatment and services provided to patients by practitioners with setting-specific privileges at Tampa General Hospital subject to the ultimate authority of the Hospital Board.

5. To ensure a generally recognized professional level of quality, efficiency, and performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges that each Practitioner may exercise in the Hospital and through an ongoing review and evaluation of each Practitioner's quality and appropriateness in providing for the uniform performance of patient care, treatment and services to an extent consistent with community resources.

6. To provide an appropriate educational setting, including its affiliation agreement with the University of South Florida College of Medicine, which will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill, to support and promote scientific standards and medical research.

7. To initiate and maintain rules and regulations for self-governance of the Medical Staff and to monitor and enforce compliance with these Bylaws, Rules and Regulations and Hospital policies.

8. To assist the Board by serving as a professional review body in conducting review activities, which include, without limitation, quality assessment, performance improvement, and peer review.

9. To pursue corrective actions with respect to members of the medical staff or those individuals granted clinical privileges, when warranted.

10. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State and local laws and regulation.

11. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff and report to and be accountable to the Board either directly or through the Chief Executive Officer.

12. To facilitate communication and cooperation between the Executive Committee, representing the Medical Staff, Hospital administration, the Board and the individual members of the Medical Staff, respectively.

ARTICLE III. APPOINTMENT and REAPPOINTMENT PROCEDURES, CONDITIONS and DURATION of APPOINTMENT and DELINEATION OF CLINICAL PRIVILEGES

Section A. Nature of Medical Staff Membership

1. Membership on the Medical Staff of Tampa General Hospital is a privilege and not a right and shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements of these Bylaws.

2. Membership on the Medical Staff of Tampa General Hospital will be open and will not be determined by academic or employment relationship to the Florida Health Sciences Center, Inc. d/b/a Tampa General Hospital or other institutions.

3. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.

Section B. Qualifications for Medical Staff Membership

1. Threshold Qualifications

No application for appointment or reappointment for membership in the Medical Staff will be accepted or considered for appointment/reappointment if the practitioner does not meet each of the threshold qualifications.

a. Practitioner must have and maintain a current, license to practice medicine, podiatry, dentistry, or psychology in the State of Florida, or meet the exceptions outlined in Florida Statute 458.303, 456.0241, 455.02 or other Florida Statute controlling the practice of active duty military practitioners. At initial appointment, the license to practice medicine, podiatry, dentistry, or psychology in the State of Florida must be unrestricted. At reappointment an exception to the requirement that the license be unrestricted may be made following review by the Credentials Committee, recommendation by the Executive Committee, and approval by the Board. At initial appointment, the license to practice medicine, podiatry, dentistry, or psychology in the State of Florida must be unrestricted.

b. Practitioner must have and maintain a current DEA registration (if applicable).

c. Practitioner must certify and provide evidence that he or she is not an excluded, terminated or suspended person for purposes of any federal or state health care program, including without limitation the Medicare and Medicaid programs.

d. Practitioner must have and maintain an active National Provider Identifier (NPI) number.

e. Practitioner must have, maintain, and provide evidence of current financial responsibility or protection pursuant to Florida Statutes 458.320(2)(a)-(c) or as amended or maintain adequate professional liability coverage through an offshore captive insurer unless the practitioner meets the exception set forth in section 458.320(5)(a). The minimum amount per state law of financial responsibility required shall be determined by the Executive Committee, subject to the approval of the Board. Florida Statue Section 458.320 Financial Responsibility states that physicians who perform surgery in a hospital must establish financial responsibility by one of the following methods:

i. Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (ii). The required escrow account amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

ii. Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 or maintain adequate professional liability coverage through an offshore captive insurer. The required coverage amount set forth in this paragraph may not be used for ligation costs or attorney's fees for the defense of any medical malpractice claim.

iii. Obtaining and maintaining an unexpired irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit not less $750,000. The letter of credit must be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and nontransferable. The letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

With the application for membership, each Practitioner shall provide evidence of his or her chosen options under Florida statute, including full information as to exceptions, exclusions or limitations and shall immediately notify Medical Staff Services of any change in the arrangement. To determine compliance with this provision, all arrangements shall be reviewed and approved by the Executive Committee, subject to further approval by the Board.

f. Practitioner must be physically and mentally capable to perform the clinical privileges requested.

g. Practitioners must have never been convicted of, or entered a plea of guilty or no contest to, any felony unless an exception is made following review by the Credentials Committee, recommendation by the Executive Committee, and approval by the Board. No exception shall be made for any felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child, elder or other)

h. At the time of initial appointment to the Medical Staff each practitioner must be board certified or board admissible and acknowledge that he or she must obtain board certification by the American Board of Medical Specialties or certification by the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Orthopedics Medicine within three (3) years of being eligible to sit for the exam, or a shorter time frame as defined in their departmental rules and regulations. If a specialty requires more than three (3) years to obtain certification, following confirmation by the Department Chair that the specialty requires additional time, a practitioner from that specialty may request that the Credentials Committee grant an extension to the three (3) year period. The Credentials Committee may grant one extension period of up to two (2) years. Failure to obtain board certification within three (3) years of being eligible to take the exam or a longer period as approved by the Credentials Committee, will be deemed a failure to continue to meet the threshold criteria during the appointment term.

Psychologists are board admissible, but are not required to hold board certification by a recognized certifying body as defined in Florida Statute Chapter 490, except as defined in the Psychology Section Rules & Regulations.

An exception may be made to the requirement for board certification or board admissibility on the basis of comparable clinical competence or institutional needs.

i. Each member of the medical staff with clinical privileges must reside and practice within the geographic area of the Hospital, close enough to provide direct patient care in a timely manner when on call or otherwise responsible for direct patient care for Practitioner's patients, unless exempted by the Board and in accordance with applicable Department or Section Rules and Regulations. Telemedicine practitioners and locum tenens practitioners may be eligible for clinical privileges but are not eligible for membership on the Medical Staff.

2. Failure to Maintain Threshold Qualifications During Appointment Term

a. In the event that a Practitioner ceases to meet any of these threshold criteria, the Practitioner must notify the Chief of Staff and the Chief Medical Officer immediately.

b. Compliance with Licensure or Financial responsibility – If a practitioner fails to provide evidence of a current license or compliance with the financial responsibility requirements set forth in Article III, Section B.1 above after receiving notification from the Medical Staff Services office by certified mail of pending expiration, the Practitioner will be temporarily administratively suspended from practice. The practitioner will then receive a 60-day grace period following the expiration date to provide the requested documentation before medical staff membership termination proceedings commence. This temporary placement on automatic suspension of Medical Staff privileges shall be considered an administrative suspension/revocation such that the Practitioner shall not be entitled to the procedural rights as outlined in these Bylaws. This 60-day grace period only applies to expirations that occur during a Practitioner's appointment term.

c. Exclusion from Government Payment Programs – In the event that a practitioner is designated as an excluded, terminated or suspended person for purposes of any federal or state program, the practitioner's membership and clinical privileges shall immediately terminate upon such exclusion, termination or suspension and such termination shall be considered an administrative suspension/revocation without recourse to the hearing and appellate review rights and procedures contained in these Bylaws. Practitioners so excluded are not eligible for reapplication of membership until the Practitioner is no longer excluded, terminated or suspended.

d. Failure to continue to meet the threshold criteria will result in immediate suspension as set forth in Article XVI of these Bylaws.

3. Additional Qualifications

a. Each Practitioner must document their current background, experience, training, quality and appropriateness of care, and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a generally recognized professional level of quality and efficiency of medical care, shall be qualified for membership on the Medical Staff. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice medicine, dentistry, podiatry, or psychology in this or in any other state, or that he is a member of some professional organization, or that he had in the past or presently has such privileges at another hospital.

b. Acceptance of membership on the Medical Staff shall constitute the staff member's certification that he has in the past, and his agreement that he will in the future, strictly abide by these Bylaws and the Principles of Medical Ethics of the American Medical Association or by the Code of Ethics of the American Dental Association or of the American Osteopathic Association or of the American Podiatric Association, or of the American Psychological Association, whichever is applicable.

c. Acceptance of membership includes responsibility to respond to requests from the Medical Executive Committee, the Peer Review Committee, the Professionalism Committee, the Credentials Committee, and the Chief Medical Officer, or any designee, within fourteen (14) days of receiving Notice. Acceptance of membership also includes responsibility for special appearance at department, section, committee or special meetings when required at the directive of the Medical Executive Committee or designee.

d. Acceptance of membership requires that the practitioner notify Medical Staff Services immediately of any changes in contact information, including pager and/or cell phone number, answering service number, email address, and all physical addresses.

e. Acceptance of membership requires that practitioner must personally and independently access and utilize the electronic medical record.

f. In order to ensure patient safety and highest quality of care, all credentialed practitioners must complete the required training in order to be granted access to use the EPIC Electronic Health Record system.

   i. All credentialed practitioners in “Active” category as well as any practitioner with more than thirteen (13) clinical encounters must complete the training.

   ii. If practitioner does not fall into category #1 above, training may be abbreviated curriculum as developed by CMIO and Organizational Development.

   iii. EPIC training must be completed before any privileges, new or renewed, will be granted.

g. TGH will provide training and adequate support to assist, when needed, practitioners entering orders into the system. Orders on paper will only be accepted under the following circumstances:

   i. Emergencies

   ii. Downtime when computer is not available

h. Each practitioner is required to have a phone that is capable of supporting the hospital required communication software and must provide his/her cell phone number to the Medical Staff Services Department.

Failure to Continue to Meet the Additional Qualifications during Appointment Term may result in corrective action as set forth in Article XVI of these Bylaws.

Section C. Rights of Medical Staff Membership

1. Each active staff practitioner has the right to an audience with the MEC. In the event such practitioner is unable to resolve a difficulty working with his or her respective department chair/section chief, he or she may, upon presentation of a written notice to the Chief of Staff two weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2. Any active staff practitioner has the right to initiate a recall election of a medical staff officer or department chief/section chief by following the procedure outlined in these bylaws regarding removal and resignation from office.

3. Any active staff practitioner may call a general staff meeting. Upon presentation of a petition signed by 10% of the active staff's members, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

4. Any officer of the medical staff can request and be granted a meeting with the officers of the Board, hospital administration, or the MEC to discuss any important issue at an agreed-upon date, place, and time.

5. Any active staff practitioner may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation, or policy is seen as inappropriate, any practitioner may submit a petition signed by 10% of the active staff members. When the MEC has received such petition, it will either provide the petitioners with information clarifying the intent of such rule, regulation, or policy, or schedule a meeting with the petitioners to discuss the issues.

6. Any member may request a department meeting when a majority of the members believe that the department has not acted appropriately.

7. The above Sections 1-6 do not pertain to issues involving professional review action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging sections. Section 8 and the hearing and appeal plan provide recourse in these matters.

8. Any member has a right to a hearing/appeal pursuant to the institution's hearing and appeal plan in the event that any of the following actions are taken or recommended:

    a. Denial of medical staff appointment and privileges

    b. Denial of medical staff reappointment

    c. Revocation of medical staff appointment

    d. Denial or restriction of requested clinical privileges

    e. Involuntary reduction/revocation of clinical privileges

    f. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a preexisting, mandatory, and concurring consultation requirement, when such requirement only applies to an individual medical staff member.

    g. Summary suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) days and is not caused by the member's failure to complete medical records or other reason unrelated to competency or conduct..

Section D. Conditions and Duration of Appointment and Reappointment

1. Initial appointments and reappointments to the Medical Staff shall be made by the Board without regard to gender, race, religion, age, creed, national origin or any other basis prohibited by law. The Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay by the Medical Staff, the Board may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff. By definition, unwarranted delay means in excess of 120 days from the date the fully completed application has been received by the Chief Executive Officer or designee.

2. Members of the Medical staff shall be appointed to a specific Department /Section

3. All appointments shall be for a period of not more than two (2) years.

4. Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as are specified in the notice of appointment in accordance with these Bylaws.

5. Following initial appointment, the individual's competence to exercise the clinical privileges granted and general conduct in the Hospital shall be evaluated by the Chief of the Department/Section in which the individual has clinical privileges. The focused review performed by the Department Chief may include direct observation, chart review, peer to peer evaluation, and review of outcomes data as it becomes available. The focus review will be completed as soon after appointment as is timely and documentation of competency can be obtained. A written evaluation will be submitted to the Credentials Committee by the Chief of the Department and/or Section.

6. Any clinical privileges granted after the initial appointment require continuing review for a period of time or number of cases/procedures as determined by the appropriate Department/Section Chief.

7. The Practitioner who has failed to earn reappointment due to failure to meet Bylaws and Department/Section requirements for board certification shall be entitled to meet with the Department/Section Chief and the Credentials Committee. At the meeting, the Practitioner shall be given an opportunity to explain why he or she did not meet the Bylaws and/or Department/Section requirements and make the case for extending the time period to obtain certification. The Credentials Committee may consult with or send a designee to consult with the appropriate Department or Section. Thereafter, the Credentials Committee will make their recommendation to the Executive Committee and the Board. The Medical Staff appointee who has failed to meet the prerequisites for continued appointment or clinical privileges is not entitled to Hearing and Appellate Review rights in Article XVII of these Bylaws.

8. When, due to questions of clinical competence or professional conduct, the Medical Staff appointment is terminated or certain clinical privileges are revoked, the recommendation shall be forwarded to the Executive Committee. The Executive Committee may reverse the recommendation of the Credentials Committee upon consultation with its chair or with the chair's designee. If the Executive Committee upholds the Credentials Committee, the recommendation shall be forwarded to the CEO who will notify the physician of the adverse action and the physician's right to a Hearing and Appellate Review as outlined in Article XVII of these Bylaws.

9. At the time of each reappointment, members of the Medical Staff with less than thirteen (13) patient encounters per year will be expected to complete the required training in order to remain proficient in the use of the EPIC Electronic Health Record System.

10. Each applicant for appointment or reappointment must sign a pledge periodically updated and approved by the Executive Committee and the Board to provide evidence of current licensure and current controlled substance registration, if applicable, relevant training and/or experience, current competence, and health status stating current ability to perform the clinical privileges requested in a form specified by the Executive Committee and agree to the following:

    a. provide continuous care and supervision of patients of a generally recognized professional level of quality and efficiency and ensure communication among all practitioners involved in the patient's care, treatment and services;

    b. arrange appropriate coverage for those patients when not available;

    c. abide by the Medical Staff Bylaws, the Rules and Regulations, and Policies and Procedures of the Medical Staff; all other lawful standards, the bylaws, policies, best practice models approved by the Medical Staff and/or the Practitioner's Department, and rules and regulations of the Hospital; and the rules and regulations of the department/section to which application or reappointment is made.

    d. accept committee assignments;

    e. accept consultation assignments;

    f. provide evidence of current financial responsibility or protection as specified by Florida and Federal law and Board and Medical Staff policy;

    g. pay Medical Staff assessments, associated late fees;

    h. provide documentation of participation in continuing medical education or continuing education relevant to the privileges granted to maintain clinical skills and current competence in an amount and distribution as required by Florida law;

    i. comply with applicable state and federal laws, rules and regulations, as well as Hospital policies and procedures, including, but not limited to, policies and procedures regarding confidentiality, privacy and security of patient information.

    j. comply with reasonable requests to present yourself at meetings of the Peer Review Committee, the Professionals Credentials Committee, and the Medical Executive Committee.

    k. abide by all Federal and State regulations pertaining to healthcare and immediately report any actions taken by any federal program regarding exclusions.

l. not be excluded, terminated or suspended from participation in any federal or state healthcare program, including without limitation the Medicare and Medicaid programs.

m. Immediately provide written notification to the Credentials Committee of any sanction of any kind imposed upon the practitioner by any other healthcare institution, professional healthcare organization, licensing authority or federal or state healthcare program, including the Medicare or Medicaid program.

n. Possess ability and demonstrate proficiency to communicate in the English language sufficient to assure that there is no risk of impairment of patient care because of difficulty in verbal communication. If an applicant's proficiency in the English language is questioned, the Chief of the Department shall make recommendations for corrective action to the Credentials Committee. The Executive Committee shall have the authority to make the final determination with regard to a required educational plan or other actions in accord with the Medical Staff Bylaws for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records including patients' medical records shall be recorded in a legible fashion in English.

o. Abide by the ethical principles of his or her profession

p. Participate in emergency department coverage and disaster coverage as assigned by the department

q. Authorize the Medical Staff to communicate identified behavior and quality concerns to the Practitioner's superior and/or employer.

11. Members agree to complete medical history and physicals examinations as follows:

a. An H&P must be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The H&P must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual, including an Advanced Practice Provider or a resident in accordance with Florida law and Hospital policy and placed in the medical records within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

b. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services when the H&P is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual, including an Advanced Practice Provider or a resident in accordance with Florida law and Hospital policy.

c. The content of H&Ps is further delineated in the Rules and Regulations.

12. Members agree to accept transfer if: 1) Hospital has beds available and 2) Practitioners provide that service electively for that type of problem (even if the transferring institution is in violation of EMTALA in making the transfer request).

13. Failure to perform the duties in item 10.a. to 10.n. may lead to corrective action as outlined in Article XVI.

Section E. Categories of Medical Staff Membership

The Medical Staff shall be divided into four (4) categories of membership: Active, Associate, Courtesy, and Honorary.

1. Active Medical Staff.

The Active Medical Staff shall consist of Practitioners who regularly admit or attend to patients in the Hospital and reside or practice within the geographic area of the Hospital in accordance with applicable Department or Section Rules and Regulations and assume all the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, and serve on Medical Staff committees, and shall be encouraged to attend Medical Staff meetings. The active members shall be eligible to hold office after at least one (1) year on the Active staff. An exception to the one-year requirement before holding office may be approved by a majority of the Executive Committee. There must be twenty six (26), in-hospital or provider based outpatient encounters, for Active Staff status per each two year recredentialing period with at least one patient encounter in the twelve (12) months immediately prior to reappointment. In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the Medical staff and Hospital, the member may be appointed to another Medical staff category if he or she meets the eligibility requirements for such category.

2. Associate Medical Staff

This category is reserved for those practitioners who are otherwise qualified for staff membership but only utilize the Hospital occasionally as exhibited by one (1) to twenty six (26) patient encounters per two (2) year recredentialing period with at least one patient encounter in the twelve (12) months immediately prior to reappointment. An exception to the requirement to have one (1) patient encounter per two (2) year recredentialing period may be made by the Board for those Physicians, Podiatrists, Dentists, Oral Surgeons, and Psychologists who possess skills not generally provided by other members of the Staff. Members with more than twenty-six (26) patient encounters per two (2) year recredentialing period must apply for advancement to the Active staff. Members of the Associate staff will participate in focused professional practice evaluation to establish competency for clinical privileges requested. Members of the Associate staff may attend medical staff/department meetings, hospital education activities and social functions. They shall not be eligible to vote, hold office or serve on medical staff committees. At the time of each reappointment, members of the Associate staff will be expected to complete the required training in order to remain proficient in the use of the EPIC Electronic Health Record System.

3. Courtesy – Refer and Follow

This category is reserved for those practitioners who maintain an office-based practice in the hospital service area and have no hospital activity. Applicants requesting this category of membership must meet all requirements of the application process. These practitioners may refer and visit their patients in the hospital and review their medical records (Read-Only). They may order outpatient tests and non-invasive procedures. They may attend medical staff meetings, medical education activities and social events. Courtesy Medical staff members shall be appointed to specific Departments, but they are not eligible for clinical privileges including Admitting privileges and therefore shall not be subject to Professional Practice Evaluations. They will not be eligible to vote, hold office or serve on medical staff committees. Members with this status may apply for privileges, but are then subject to the requirements of these Bylaws related to privileging to attain Active or Associate status. Members of this category shall comply with any applicable medical staff or hospital policies and procedures.

4. Honorary Medical Staff

The Honorary Medical Staff shall consist of Practitioners who are not practicing in the Hospital and/or who are honored by emeritus positions. These may be Practitioners who have retired from Hospital practice or who are of outstanding reputation, who have made noteworthy contributions to the health and medical sciences or who have provided distinguished service to the Hospital. These practitioners are not necessarily residing in the community. Honorary Medical Staff members shall not be eligible to admit patients, order tests, consult on patients, or otherwise care for patients or exercise clinical privileges. They may attend medical staff meetings, medical education activities and social events. They may be appointed to committees. They cannot hold office. They can only participate on those committees to which they have been appointed. Appointment to this category is entirely discretionary and may be rescinded at any time. They are not subject to reappointment. Procedural or fair hearing rights do not apply to the failure to grant, or termination of Honorary status. Members of the Honorary Medical Staff may apply or reapply for active membership, but are subject to all the requirements of these Bylaws for application and credentialing to attain active status

Section F. Contractual Physicians

1. Staff members employed by a physician group under contract with the Board shall have the same rights and privileges as other Medical Staff members including the right to a fair hearing pursuant to Article XVII of these Bylaws.

    a. A contractual physician who Separates from (ceases to provide services or be employed by) an exclusive contractor will be deemed to voluntarily relinquish his or her Privileges in the services covered in the Exclusive Contract as of the date of such Separation (the effective date). Notification to the Medical Staff Office of the effective date of the physician Separation from the Exclusive Contract will be the responsibility of the exclusive contractor and must be in writing. Failure to give notice does not affect the deemed relinquishment of Privileges. Medical Staff membership may be maintained at the physician's written election, without privileges in the exclusive services covered under the Exclusive Contract. If continuation of Medical Staff membership is desired, the physician so affected must notify the Medical Staff Office within thirty (30) calendar days of notification of his or her Separation From the exclusive contractor. Failure to give notice will be deemed the physician's voluntary resignation from Medical

Staff membership and voluntary relinquishment of all privileges as of the effective date.

2. Continuation of Medical Staff membership may not be made contingent on the existence of a contract for practitioners appointed to administratively responsible positions.

Section G. Leave of Absence

1. Leave Status.

At the discretion of the Executive Committee, a member of the Active or Associate Medical Staff may obtain a voluntary leave of absence for either personal, medical reasons or because of military service. For the purpose of this section a leave of absence is defined as an absence not less than 90 days and no more than two years. A leave of absence may not extend beyond the member's date of reappointment.

The Medical Staff member desiring a leave must submit a written request to the Chief of his/her pertinent department with a copy to the Credentials Committee clearly identifying the reasons for the voluntary leave and stating the approximate period of leave desired, which may not exceed the member's current term of appointment. The Chief shall forward approval or other recommendation to the Credentials Committee who shall submit their recommendation to the Medical Executive Committee. During the period of the leave, the member will not exercise clinical privileges at the Hospital, and membership rights and responsibilities are inactive, but the obligation to pay staff dues and meet membership requirements, if any, will continue, unless waived by the Medical Staff.

By requesting a leave of absence the member understands he/she will be treated as an initial applicant for the purpose of evaluating his/her qualifications for reinstatement and the applicant further understands and agrees he/she shall bear the burden of proof to demonstrate to the satisfaction of the Executive Committee and the Board that he/she is qualified for reinstatement. If his/her current appointment expires before the allowable days for leave of absence and he/she wishes to continue in this status, one must complete the reappointment process in accordance with these Bylaws and may request continuance of the leave of absence.

Members of the Medical Staff on an approved leave of absence for the purpose of active duty with the Armed Forces of the United States, shall be reinstated to the Medical Staff in accordance with applicable state and federal laws.

2. Granting of Leave

A leave of absence shall be granted for members in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a medical staff member has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters.

3. Termination of Leave

With the exception of military leave of absence, at least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff

member may request reinstatement of privileges by submitting a written notice to that effect to the Executive Committee which will be processed in the same manner as a request for a leave of absence. The written request must include a summary of relevant activities during the leave, including evidence of health and competency. The Credentials Committee may request an interview with the member before approving the member's request for reinstatement. The credentials and request will be reviewed by the Credentials Committee and privileges delineated as specified by the reappointment procedures of these Bylaws. The Executive Committee will make a recommendation concerning the reinstatement of the member's privileges and prerogatives. A determination that a member be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these Bylaws.

4. Failure to Request Reinstatement

Failure, without good cause, to request reinstatement in a timely manner, or to submit to a requested interview shall be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of staff membership, privileges and prerogatives. A request for staff membership subsequently received from a practitioner so terminated will be submitted and proceed in the manner specified for applications for initial appointment. Reinstatement following resignation may be considered under the same terms and conditions herein set forth.

Section H. Resignations

Any practitioner may voluntarily resign from the Medical Staff by notifying Medical Staff Services in writing and stating the date the resignation becomes effective. Medical Staff Services will notify the respective Department Chief and Chief of the Medical Staff, with a copy to the Credentials Committee. The practitioner is required to complete medical records, pay any outstanding assessments and make provisions for continuity of care for his/her patients. Without written notice, non-compliance with the reappointment process or maintaining evidence of current financial responsibility also constitutes resignation.

ARTICLE IV. PRIVILEGES

Section A. Clinical Privileges

Except as otherwise provided in these Bylaws, a member of the Medical Staff providing clinical services at this Hospital will be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, site specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions, and will be subject to Article XV of these Bylaws, Rules and Regulations of the Department/Section and the authority of the Department/Section Chief and the Medical Staff. Clinical privileges shall be granted for a period of not more than two (2) years.

Section B. Temporary Privileges

Temporary privileges may be granted to an applicant in accordance with the procedures described in Article XV – Medical Staff Credentialing. Temporary privileges may be granted for a period not to exceed 120 days. Temporary privileges may be revoked at any time without prior notice as per Medical Staff

Policy, and such revocation shall not entitle the applicant to a hearing or other due process as described in Article XVII, unless revoked for a reason of competence or conduct.

Section C. Emergency Privileges

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in imminent danger and any delay in administering treatment would add to that danger. In the case of an emergency, any member of the Medical Staff, to the degree permitted by his or her license and regardless of Department, staff status, staff category, or clinical privileges, will be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm, including the loss of limb or function, using every available resource of the Hospital necessary, including the calling for any consultation necessary or desirable. The member will make every effort to communicate promptly to the Department Chief concerning the need for emergency care and once the emergency has passed or assistance has been made available, will defer to the Department Chief with respect to further care of the patient at the Hospital.

Section D. Disaster Privileges

In the event of a declared disaster in which Tampa General Hospital's Emergency Management Plan has been activated, all practitioners providing patient care services that are not current members of the Medical Staff, must be granted disaster privileges prior to providing patient care. In accordance with the Medical Staff Bylaws and the Plan, a practitioner who is needed to supplement or substitute for a medical staff member(s) and who is not a member of the medical staff and who has no current privileges, may acquire privileges at any TGH facility during a "disaster" (defined as any officially declared disaster whether it is local, state or national). The CEO, Chief of Staff, or his/her designee may grant emergency temporary privileges following review of required documents by a hospital representative according to the process outlined in Article XV, Section II.E.

ARTICLE V. OFFICERS

Section A. Officers of the Medical Staff

The officers of the Medical Staff shall be Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and Immediate Past Chief of Staff

Section B. Qualifications of Officers

Officers must be physicians currently licensed under the provisions of F.S. 458 or 459 and a member of the Active Category of the Medical Staff in good standing for at least one (1) year at the time of nomination and election and must continuously maintain such status during their terms of office, as well as demonstrate commitment to the support of the Medical Staff and active in Medical Staff activities. An exception to the one-year requirement before holding office may be approved by a majority of the Executive Committee. Failure to maintain the status of good standing shall immediately create a vacancy in the office involved. Officers must be willing to faithfully fulfill the duties and responsibilities of the position to which they are elected. Officers may not hold leadership positions with any other hospital or health system or its medical staff.

Section C. Election of Officers

1. Officers shall be elected by a majority of those voting during the annual meeting of the Medical Staff. Members of the Active Medical Staff Medical Staff who meet requirements shall be eligible to vote.

2. Five (5) members-at-large, from three (3) categories of members, shall be elected by a majority of those eligible voters. The three (3) categories are: 1) TGMG/FHSC Employees, 2) USF employees, and 3) not employees of USF or TGMG/FHSC. One (1) member-at-large must be elected from category #1 (TGMG/FHSC employees), two (2) members-at-large must be elected from category #2 (USF employees), and two (2) members-at-large must be elected from category #3 (not employees of USF or TGMG/FHSC).

3. Nominations

    a. The Medical Staff Officer Committee shall prepare a slate of officers, which will be presented to the Executive Committee at least 60 days prior to the annual meeting for its approval. Unless unwilling or unable to serve, the slate shall propose the current Vice Chief for Chief, the current Secretary/Treasurer for Vice Chief, at least one (1) candidate for Secretary/Treasurer and at least five (5) members of the Active Medical Staff for the Member at large positions. In order to promote representative leadership, the slate of members for the position of member at large shall consist of at least one (1) member who is an employee of TGMG/FHSC, two (2) members who are employees of USF, and two (2) members who are not employees of USF or TGMG/FHSC. In the event a current Vice Chief or Secretary/Treasurer is unwilling or unable to serve the next term, the Medical Staff Officer Committee shall nominate an alternate for that position. Those nominated for Secretary/Treasurer must be willing to serve as an officer for the next eight (8) years. The slate will be announced to the Medical Staff at least 30 days before the election.

    b. Additional nominations may be made from the floor if accompanied by 100 signatures of staff members eligible to vote and with written consent of nominee(s).

    c. The Medical Staff Officers committee and Medical staff should make a strong effort to nominate staff members who regularly admit patients to the Hospital, who demonstrate qualification and leadership abilities and who contribute to the welfare of the Medical Staff.

4. Voting

    a. Electronic ballots shall be cast on the day of the Annual Meeting

    b. Each member may cast one (1) vote for Chief, one (1) vote for Vice-Chief, one (1) vote for Secretary/Treasurer, one (1) vote for category #1 member-at-large, one (1) vote for category #2 member-at-large, and one (1) vote for category #3 member-at large positions.

    c. Only votes cast on the day of the annual meeting will be counted. Medical Staff Services will count the votes.

Section D. Term of Office

Each officer shall serve a two-year term. An elected Chief of the Medical Staff cannot succeed himself. The term of office shall take effect on the first day of the Medical Staff Year following the election or earlier if the office is vacant.

Section E. Vacancies in Office

Vacancies in office during the Medical Staff Year, except for the Chief of Staff or Immediate Past Chief of Staff, shall be filled by the Executive Committee for the balance of the term. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve until the general Medical Staff meeting at which time an election shall be held.

In the event of vacancy in the office of the Immediate Past Chief of Staff caused by incapacity, inability or unwillingness to fulfill the office, removal for cause, or resignation, the most recent Active Medical Staff member who previously filled the office shall be appointed for the unexpired term, subject to such person's consent.

Section F. Duties of Officers

1. The Chief of Staff shall:

serve as the Chief administrative officer of the Medical Staff and shall have responsibilities for supervision of the general offices of the Medical Staff. The specific responsibilities, duties, and authority of the Chief of Staff are to:

a. act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;

b. calls, preside at, and be responsible for the agenda of all general, special and executive committee meetings of the Medical Staff;

c. act as chair of the Medical Staff Officers committee.

d. serve as ex-officio member of all other Medical Staff committees;

e. be responsible for the enforcement of Medical Staff Bylaws and Medical Staff Rules and Regulations, for implementation of sanctions when these are indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a Physician or other individual with clinical privileges;

f. appoint committee members and chairmen (except as specified) to all standing, special, ad-hoc, and multi-disciplinary Medical Staff committees except the Executive Committee;

g. appoint an Investigative Panel. The Investigative Panel shall be a multidisciplinary panel consisting of a minimum of six (6) active members of the medical staff in good standing who have agreed to be appointed as members of the Investigative Committee during Corrective Action as needed.

h. represent the views, policies, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board;

i. receive and interpret the policies of the Board to the Medical Staff and report to the Board about the performance and assurance of quality care with respect to the Medical Staff's delegated responsibility to provide medical care;

j. be responsible for the educational activities of the Medical Staff; and be the spokesperson for the Medical Staff in its external professional and public relations.

k. carries out specific responsibilities as identified in Attachment A.

2. The Vice Chief of Staff shall:

a. assume all the duties and have the authority of the Chief of Staff in his absence;

b. be a member of the Medical Staff Officers committee.

c. act as chair of the Professionalism Committee

d. be a member of the Executive Committee;

e. automatically succeed the Chief of Staff when the latter fails to serve for any reason; and

f. be a voting member of the Credentials Committee.

g. carries out specific responsibilities as identified in Attachment A.

3. The Secretary-Treasurer shall:

a. Be a member of the Medical Staff Officers committee.

b. be a member of the Executive Committee;

c. shall assure the completion of minutes of all Medical Staff meetings;

d. oversee formal and informal modes of communication to the Medical Staff;

e. prepare a yearly Medical Staff funds budget, administer the distribution of Medical Staff funds and the collection of staff assessments, and prepare monthly distribution reports for the Executive Committee;

f. be co-chair of the Quality Council, and

g. carries out specific responsibilities as identified in Attachment A.

4. The Immediate Past Chief of Staff shall:

a. assume all the duties and have the authority of the Chief of Staff in the absence of the Chief and Vice Chief of Staff;

b. be a member of the Medical Staff Officer Committee and;

c. be a member of the Executive Committee and;

d. be Chairman of the Medical Staff Bylaws Committee.

e. oversee the peer review process.

f. carries out specific responsibilities as identified in Attachment A.

Section G. Removal of Officers

The Medical Executive Committee may remove any officer for failure to conduct those responsibilities assigned within the Bylaws or other Policies and Procedures of the Medical Staff or conduct detrimental to the interest of the hospital or medical staff.

At the request of not less than six (6) members of the Medical Executive Committee, a written and signed notification for consideration for removal of an officer for specific reason may be submitted to all members of the Medical Executive Committee with not less than seven (7) days' notice prior to a regularly scheduled Medical Executive Committee meeting. The involved officer shall be notified at the time of the notice.

A 2/3 vote of the Medical Executive Committee is required to remove any officer. There are no rights to appeal or access to hearing process for removal of an officer.

Any officer with an enforcement action under the provisions of these Bylaws shall vacate the office pending review by the Executive Committee. Upon recommendation of the Executive Committee, the office vacated shall be filled in accordance with Section E of Article V of these Bylaws.

ARTICLE VI. CLINICAL DEPARTMENTS

Section A. Departments and Sections and Assignments

The Executive Committee upon recommendation of the Credentials Committee and approval by the Board shall assign each Medical Staff member and qualified Advanced Practice Provider to function in the appropriate Departments and Sections. Sections within a Department may be established or abolished upon recommendation of the Chief of any Department with approval of the Executive Committee and as described in the Creation and Dissolution of Departments and Sections Policy. The Medical Staff shall be organized into Clinical Departments and Sections

Section B. Functions of Clinical Departments and Sections

Each clinical Department and its respective Sections shall adopt rules and regulations to:

1. Establish criteria, consistent with, these Bylaws and the policies of the Medical Staff and the Board for granting, withdrawing and modifying of clinical privileges designed to ensure patients receive generally recognized professional level of quality and efficiency;

2. Establish qualifications, selection, and tenure of officers;

3. Involve the members of the Department/Section in monitoring and evaluation activities including the identification of the important aspects of the care provided

by the Department, the identification of indicators to be used to monitor the quality of care, and the evaluation of the care provided;

4. Review as data becomes available patient care to draw conclusions, formulate recommendations and initiate actions based on the findings of monitoring and evaluation activities for the purpose of improving and/or maintaining the quality of care in the department. The review should occur, as often as deemed necessary. Its frequency is to be determined based on the subject of the review and the frequency of the occurrence of the reviewed event. The mechanism(s) should provide timely review, for example, immediate review of sentinel events.

5. Communicate to appropriate members of the Department/Section the findings, conclusions, recommendations and actions taken, specifically those from peer review activities to ensure uniform patient care processes.

6. Members in the department of the hospital must accept emergency patient transfers from other hospitals for the same types of medical services that are provided on an elective basis, subject to availability of beds suitable for the purpose and without regard to the patient's payer status.

Section C. Officers

The term of office of all officers shall be two (2) years. Officers shall take office on the first day of the Medical Staff Year or earlier if the office is vacant.

1. Chiefs of Departments

a. Each Department shall be organized under the direction of a chief who shall be responsible to the Executive Committee for the functioning of the Department and who shall have supervision over all clinical work coming within the jurisdiction of the Department as well as assuring that the quality and appropriateness of patient care are monitored and evaluated.

b. Each Chief of a Department shall ensure the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the Department and the clinical performance of all individuals with clinical privileges in the Department.

c. Each Chief of a Department shall be an eligible member in good standing of the Active Medical Staff practicing primarily in this Hospital who demonstrates an interest in and appreciation for the clinical programs of patient care, teaching, and research.

d. Each Chief of a Department shall be elected by the members of his or her Department, and shall be certified by an appropriate specialty board, one of the twenty-four boards of the American Board of Medical Specialties or certified by the American Osteopathic Association, or have affirmatively established comparable competence through the credentialing process.

e. Each Chief of a Department shall:

i. be accountable to the Executive Committee for all professional, administrative and clinical activities of the Department. Failure to perform any of the responsibilities over two consecutive months

or three incidents during a year shall initiate a warning from the Chief of Staff. Any subsequent failure shall result in the initiation of removal from office by the Executive Committee.

ii. be a member of the Executive Committee and ensure representation by the Chief or Vice Chief at monthly meetings;

iii. provide oversight and participate in administratively related activities of the department, unless otherwise provided by the hospital;

iv. review and recommend clinical privileges for each practitioner in the department, and ensure mechanisms for revising clinical privileges;

v. maintain continuing ongoing review of the professional performance of all Practitioners in the Department who have delineated clinical privileges ensuring the same level of quality of patient care is provided by attending the Department Ongoing Professional Practice Review Committee meetings scheduled no less than twice each year;

vi. recommend to the Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the Department, including evidence of current competence and peer recommendations, when required;

vii. counsel Practitioners as necessary with regard to the exercise of their clinical privileges and provide written recommendations to the Practitioner with regard to actions to improve or enhance the quality of care;

viii. assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;

ix. assist in the integration of the department into the primary functions of the organization with the coordination and integration of interdepartmental and intradepartmental services;

x. collaborate the development and implementation of policies and procedures that guide and support the provision of patient care, treatment, and services;

xi. assist the Medical Staff and administration in recommending a sufficient number of qualified and competent support personnel to provide patient care, treatment and services;

xii. assist the Medical Staff and administration in the determination of the qualification and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

xiii. continuing medical education or continuing education is documented by attestation. Specific documentation related to

department or section requirements may be based on the scope of services provided by the department, privilege requirements, changes in medical practice or technology and the results of department performance improvement activities;

xiv. make recommendations for space and other resources needed by the department or services;

xv. be responsible for enforcement of the Hospital Bylaws, these Bylaws, Medical Staff Rules and Regulations, and Quality Outcomes Program within the Department;

xvi. be responsible for implementation within the Department of actions taken by the Executive Committee;

xvii. make recommendations concerning initial appointment, the staff classification, the reappointment, and the delineation of clinical privileges for all Practitioners in his Department, which should be in compliance with the timeframe outlined by the Credentials Committee.

xviii. be responsible for the conduct and coordination of continuous assessment, improvement, and peer review activities and for ensuring that the results of those activities are used in the ongoing evaluation of Department staff member performance;

xix. interview all new applicants seeking membership in the Department and;

xx. coordinate all teaching and research activities with the appropriate Department Chairman of the College of Medicine

xxi. maintenance of quality control programs, as appropriate; and

xxii. facilitate orientation and continuing education of all persons in the section or service.

2. Chiefs of Sections

a. Each Section shall be organized under the direction of a Chief who shall be responsible to the Chief of the Department for the functioning of the Section and who shall have supervision over all clinical work coming within the jurisdiction of the Section as well as assuring that the quality and appropriateness of patient care are monitored and evaluated. Failure to perform any of the responsibilities over two consecutive months or three incidents during a year shall initiate a warning from the Chief of the Department and/or Chief of Staff. Any subsequent failure shall result in the initiation of removal from office by the Executive Committee.

b. Each Chief of a Section shall assure the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the patient care, treatment and services provided by the Section and the clinical performance of all individuals with clinical privileges in the Section.

c. Each Chief of a Section shall be an eligible member in good standing of the Active Medical Staff practicing primarily in this Hospital who demonstrates an interest in and appreciation for the clinical programs of patient care, teaching, and research.

d. Each Chief of a Section shall be elected by members of the Section, and shall be certified by an appropriate specialty board, one of the American Board of Medical Specialties or certified by the American Osteopathic Association, or have affirmatively established comparable competence through the credentialing process.

e. Each Chief of a Section shall:

i. be accountable to the Chief of the Department for all professional and administrative activities within the Section;

ii. maintain continuing surveillance of the professional performance of all Practitioners with clinical privileges in the Section and report regularly to the Chief of the Department, the development of criteria for the delineation of clinical privileges in the Section;

iii. counsel Practitioners as necessary with regard to the exercise of their clinical privileges and provide written recommendations to the Practitioner with regard to actions to improve or enhance the quality of patient care, treatment and services;

iv. be responsible for enforcement of the Hospital Bylaws, Medical Staff Bylaws, Medical Staff Rules and Regulations, and Quality Improvement Program within the Section;

v. be responsible for implementation within the Section of actions taken by the Department and the Executive Committee;

vi. transmit to the Credentials Committee recommendations concerning initial appointment, the staff classification, the reappointment, and the delineation of clinical privileges for all Practitioners in the Section;

vii. be responsible for the conduct and coordination of peer review activities and for ensuring that the results of those activities are used in the ongoing evaluation of Section staff member performance and by attending the quarterly Ongoing Professional Practice Review Committee meetings;

viii. interview all new applicants seeking membership in the Section; and

ix. coordinate all teaching activities with the appropriate Department Chairman of the College of Medicine.

x. assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the section or the organization;

xi. assist in the integration of the section into the primary functions of the organization with the coordination and integration of intersectional and intra-sectional services;

xii. collaborate with the development and implementation of policies and procedures that guide and support the provision of services in the section;

xiii. assist the Medical Staff, department chair and administration in and recommending a sufficient number of qualified and competent support personnel to provide patient care, treatment and services;

xiv. assist the Medical Staff, department chair and administration in the definition of the determination of the qualification and competence of section or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

xv. facilitate orientation and continuing education of all persons in the section or service;

xvi. make recommendations for space and other resources needed by the section or services.

xvii. Assist the Department Chief and Chief Medical Officer in appointing a physician in the Section to take over a case when the physician/patient relationship is irreparably damaged. This may ultimately result in the Section Chief accepting the case.

3. Vice Chiefs of Departments and Vice Chiefs of Sections

a. These officers are elected by members of the Department or Section from their own membership. The Chief of the Department or Section may not simultaneously hold the position of Vice-Chief.

b. In the absence, resignation or removal of the Chief, the Vice Chief shall assume all the duties and authority of the Chief.

c. Department and Section Chiefs may delegate appropriate duties to Vice Chiefs of their Department or Section as circumstances may require.

4. Election

Election shall be subject to approval of the Board in accordance with its policies and procedures

Section D. Vacancies

Vacancies in office of Vice Chief and Secretary (if applicable) will be determined by the Rules and Regulations of the Department/Section.

Section E. Removal

The Medical Executive Committee may remove any departmental officer for failure to conduct those responsibilities assigned within the Bylaws, the Policies and

Procedure of the Medical Staff, or conduct detrimental to the interest of the hospital or medical staff.

At the request of not less than six (6) members of the Medical Executive Committee, a written and signed notification for consideration for removal of an officer for specific reason may be submitted to all members of the Medical Executive Committee with not less than seven (7) days' notice prior to a regularly scheduled Medical Executive Committee meeting. The involved officer shall be notified at the time of the notice.

A 2/3 vote of the Medical Executive Committee is required to remove any officer.

There are no rights to appeal or access to hearing process for removal of a department/section officer.

ARTICLE VII. COMMITTEES

Section A. Standing Committees

The Florida Health Sciences Center CEO and the Chief Medical Officer shall be ex-officio members on all Standing Medical Staff Committees. The Standing Committees shall be Medical Staff Officer, Executive, Professional Credentials, Bylaws, Infection Prevention and Control, Health Information Management, Pharmacy and Therapeutics, Surgical Suite, Critical Care Steering, Trauma Program Operational Process Performance, Cancer, Peer Review, and Practitioner Health Advisory Committee.

Unless otherwise stated in these Bylaws, Medical Staff committee members shall be appointed by the Chief of Staff for a term beginning January 1. A Chairman, Vice-Chairman and members shall be appointed for a two (2) year term. A quorum at standing committee meetings shall be those members present.

1. Attendance

Unless otherwise stated in these Bylaws, the Chair of the Medical Staff and/or the Chair of any Committee or Department may allow its Members to attend, participate and vote at meetings by telephone, virtually or by other electronic means.

2. Executive Committee

a. Composition: the Executive Committee shall consist of:

i. the Officers of the Medical Staff;

ii. the Chief of each Department;

a. In the event that any one department has membership greater than twenty-five percent (25%) of the voting Medical Staff, the Vice Chief of that department shall also be a member

b. Percentage justification for this additional member shall be made prior to bi-ennial department elections.

iii. three (3) at large members from the Medical Staff

a. to be nominated and elected bi-annually at the annual meeting of the Medical Staff;

b. must be an eligible Active members of the Medical Staff

c. if there is a vacancy during the 2-year term, the Executive Committee may appoint a new at large member for the balance of the term of office. The appointee may not be an existing member of the Executive Committee as a result of holding any other position.

iv. the Chair of the Credentials Committee;

v. the Chair of the Peer Review Committee;

vi. the Chief Executive Officer, the Chief Operating Officer, the Chief Medical Officer, the Executive Vice President of Finance & Administration, and the Executive Vice President for Patient Services, who shall be ex-officio members without vote

vii. The USF Designated Institutional Official, who shall be a non-voting member.

viii. An APP representative, who shall be a non-voting member.

ix. Others as invited by the Chief of Staff as non-voting attendees.

b. The duties of the Executive Committee shall be:

i. to make recommendations to the Board regarding the medical staff structure;

ii. to represent and to act on behalf of the organized Medical Staff in the intervals between Medical Staff meetings subject to such limitations as may be imposed by these Bylaws;

iii. to coordinate the activities and general policies of staff committees and clinical departments;

iv. to receive and act on reports and recommendations from Medical Staff and Hospital committees, clinical Departments, Sections, and services and assigned activity groups;

v. to oversee the ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes and providing oversight in the process of analyzing and improving patient satisfaction;

vi. to lead the assessment and improvement of both clinical and non-clinical processes and the resulting patient outcomes primarily dependent on individuals with clinical privileges.

vii. to implement policies pertaining to the Medical Staff not otherwise the responsibility of the Departments and present for adoption to the Board;

viii. to designate ad-hoc committees of the Medical Staff, as necessary, to perform specific studies and/or make recommendations to the Executive Committee. All such ad hoc committees shall be authorized only for a designated period of time in order to accomplish a specified purpose;

ix. to provide liaison between Medical Staff and the Chief Executive Officer and to make recommendations directly to the Board for its approval;

x. to fulfill the Medical Staff's accountability to the Board for the overall quality, safety and efficiency of medical care rendered to the patients in the Hospital from a licensed independent practitioner who has been credentialed through the medical staff process during the entire length of stay;

xi. to ensure Medical Staff compliance with accreditation standards and keep the Medical Staff informed of the accreditation status of the Hospital;

xii. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

xiii. to determine the mechanism for establishing and monitoring patient care standards and credentialing and delineation of clinical privileges;

xiv. to review the credentials of all applicants and to submit recommendations to the Board for staff membership, assignments to Departments, Sections, Staff Category, and delineation of setting-specific clinical privileges; and request evaluations of practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested;

xv. to review periodically all information available regarding the performance and clinical competence of staff members and other Practitioners with clinical privileges and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges; request evaluations of Practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested, and as a result of such reviews, to make recommendation for reappointment and renewal or implementation of clinical privileges to the Board;

xvi. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including initiating investigation when appropriate and/or participation in Medical Staff corrective or review measures when warranted.

xvii. Oversee corrective action for disruptive physicians.

xviii. to provide a mechanism by which Medical Staff membership may be terminated and to implement the mechanism for fair hearing procedures in accordance with these Bylaws; and

xix. to recommend to the Board the removal of any officer of the Medical Staff, officers of Departments and Sections, and committee chairmen, for cause defined as: Failure to conduct those responsibilities assigned by these Bylaws or conduct detrimental to the interest of the Medical Staff or hospital. An affirmative vote of two-thirds of the committee is necessary to make this recommendation.

xx. to participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs and goals consistent with the mission and philosophy of the Board.

c. Meetings shall be held at least ten (10) times a year and a permanent record of proceedings and actions will be maintained in the Medical Staff Office. A Quorum shall be ten (10) voting members. Additional meetings may be called by the Chief of Staff. Attendance is required of members unless excused by the Chief of Staff; however, the Vice Chief of a Department/Section or designee may attend with voting privileges in the event of an excused absence. The attendance requirement is fifty (50%). For good cause and following approval by the Chief of Staff, a member may attend the meeting by telephone conference call**, virtually** or **by** other electronic means. Failure to attend 50% of the meetings either by any method will result in replacement on the committee.

d. All actions taken by the Medical Staff Executive Committee shall be considered actions of the medical staff.

3. Medical Staff Officers

a. Composition: the Medical Staff Officer Committee shall consist of the current Officers of the Medical Staff;

b. The duties of the Medical Staff Officer Committee shall be to act as an advisory board to the Executive Committee, including but not limited to the following:

i. to make recommendations regarding the medical staff structure;

ii. to review and make recommendations on reports and recommendations from Medical Staff and Hospital committees, clinical Departments, Sections, and services and assigned activity groups;

iii. to provide oversight to the ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes and providing oversight in the process of analyzing and improving patient satisfaction;

iv. to provide advice regarding the assessment and improvement of both clinical and non-clinical processes.

v. to review proposed policies pertaining to the Medical Staff not otherwise the responsibility of the Departments and provide advice regarding adoption

vi. to recommend certain ad-hoc committees of the Medical Staff as necessary;

vii. to assist the Executive Committee with ensuring the Medical Staff compliance with accreditation standards;

viii. to advise the Executive Committee regarding the mechanism for establishing and monitoring patient care standards and credentialing and delineation of clinical privileges;

ix. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff.

c. Meetings: The Committee shall meet at least ten (10) times a year and a permanent record of proceedings and actions will be maintained in the Medical Staff Office. Additional meetings may be called by the Chief of Staff.

d. Attendance is required unless excused by the Chief or Vice Chief.

4. Credentials Committee

a. Composition

i. A Chair and Co-Chair appointed by the Chief of the Medical Staff with vote

ii. The Vice Chief of the Medical Staff with vote

iii. At least eight other active staff members appointed by the Chief of the Medical Staff seeking broad representation among the medical disciplines of the Medical Staff, with consideration to include those experienced in medical staff leadership, each with vote.

iv. An APP representative from the Advance Practice Provider Credentialing and Authorization Committee (APPCAC), who shall be a non-voting member.

v. Chief Medical Officer of the Hospital, ex officio without vote

vi. All appointments are for one (1) year. Members may serve an unlimited number of terms.

b. Duties of the Credentials Committee

The Credentials Committee shall perform the key functions of credentialing, as further described in Article XV of these Bylaws, under the oversight and direction of the Medical Executive Committee. The Credentials Committee will review evidence of the character, professional competence, ability to perform the privileges requested, qualifications and ethical standing of the applicant and determine, through information contained in references and other sources available to the Committee, including the report of the Chief of the Department or Section and letters of recommendation, for APPs, the report from the APPCAC, whether the applicant meets all the necessary qualifications for the category of staff membership and clinical privileges requested. The Committee may, at its option, elect to interview the applicant and seek additional information.

a. At the next meeting of the Committee or as soon thereafter as is practical (but not to exceed 30 days), after receipt of the Department/Section Chief recommendation, and for APPs, the recommendation from the APPCAC, and the completed application for membership, the Committee will submit to the Executive Committee a written report and, if appointment is recommended, assign the membership category, department affiliation, clinical privileges to be granted, and any special conditions related to the appointment.

b. The Committee will recommend the applicant be either:

i. Granted the clinical privileges requested and if applicable, appointed to the Medical Staff with written delineated privileges,

ii. Denied the clinical privileges requested and if applicable, rejected for Medical Staff membership,

iii. the application be deferred for further consideration.

c. If the Chief of the Section/Department or for APPs, the APPCAC submits an adverse recommendation, no action may be taken without the presence of a representative prepared to discuss the adverse recommendation with the committee. Each review shall be conducted in compliance with Articles V and VI of the Medical Staff Bylaws.

ii. The Committee will review reappointment applications as submitted by Departments and Sections, and the APPCAC, and make recommendations to the Medical Executive Committee for reappointment vs. non-reappointment, clinical privileges, and staff category changes, as applicable.

a. The Committee will review quality-outcomes data, variance reports, medical records completion data, Disruptive Physician reports, Corrective Action data, National Practitioner Data Bank and any other information

in the individual applicant's Credentials file in making its determination.

b. The Committee will review the qualifications, competence, clinical performance of all applicants and membership performance of all members and make recommendations to the Medical Executive Committee.

c. The Committee may edit, recommend denial and/or attach written stipulations or amendments to privileges with written justification. An applicant whose privileges have been denied or limited retains the right to a Fair Hearing and Appellate Review.

d. The Committee will make written recommendation to the Executive Committee concerning the reappointment or non-reappointment of each practitioner scheduled for a periodic appraisal, including the specific clinical privileges to be renewed or granted to each practitioner reappointed for the ensuing period.

e. If non-reappointment or a change in clinical privileges is recommended, the reasons for such a recommendation will be outlined in writing, submitted to the Executive Committee, and placed in the practitioner's file. The Executive Committee shall meet in closed session and may take either of the following actions:

i. The Executive Committee may elect to accept the Credentials Committee report without comment and forward such to the Board.

ii. The Executive Committee may review, and suggest alteration of the Credentials Committee report. The Credentials Committee shall, at its next session after consideration of a written report from the Chief of Staff on the outcome of the Closed Session, make a final recommendation to the Executive Committee. The Executive Committee, at its next regularly scheduled meeting, may accept or alter the Credentials Committee report and forward its final decision to the Board as outlined in Article XV of these Bylaws. When the Board accepts the final recommendation, a copy of the Committee's report will be forwarded by certified mail to the practitioner who will retain Bylaws right to Fair Hearing and Appellate review.

iii. Review practitioner issues as they arise that may affect the ability of the practitioner to function independently in the Hospital.

a. Manage practitioner monitoring mandated by privileging, corrective action, variance reports, Physician Health Advisory Committee reports, or other processes;

i. e.g., when a number of certain types of cases must be done in order to acquire independent privileges outside of the regular two year reappointment process, reports of clinical activity shall be reviewed by the Committee to establish independent practitioner status for specified privileges.

ii. e.g., when a Corrective Action report, Disruptive Physician report, Physician Health Policy, Variance Report agreement or other action results in a monitoring requirement, the Committee shall receive, review, and make recommendations of pertinent reports and related information in a manner stipulated by the action.

b. Any breach of ethics

c. Quality-of-care issues that result from Variance Reports or other sources

d. Corrective Action that affects privileges, monitoring, or other oversight of a practitioner

e. When Corrective Action, Fair Hearing, Appellate Review, or other processes raise a question with regard to a conflict of interest, whether apparent or perceived, the Committee shall review and decide on such questions. The Committee shall make such reports to the Chief of the Medical Staff to manage the Committee opinion.

f. The procedures and powers of this committee shall be in accordance with applicable Florida Statutes.

iv. The Committee shall be responsible for reviewing and approving Department/Section delineation of privileges including, but not limited to the following:

a. Discipline specific privileges for physicians

b. An ad hoc Multi-disciplinary Committee recommendation regarding criteria for privileging that crosses specialties.

c. Department and practitioner specified scope of practice and privileging of Advanced Practice Providers whether dependent or independent.

d. Review criteria for Department delineation of privileges and any interdepartmental procedures and make recommendations to the Executive Committee.

v. The Committee shall review all requests for Leave of Absence (LOA) and reinstatements from leave of absence and make appropriate recommendations to the Executive Committee.

vi. Meetings: The Committee shall meet at least ten (10) times a year. The Committee shall maintain a permanent record of proceedings and actions and shall report to the Medical Executive Committee.

vii. Quorum: A quorum of this committee shall consist of fifty percent (50%) of the voting members. When dealing with requests for routine appointment, reappointment, and clinical privileges in which the applicant is eligible for expedited credentialing, the MEC quorum will consist of at least three members.

viii. Attendance: The attendance requirement is fifty percent (50%). Failure to attend 50% of the meetings may result in replacement on the committee.

5. Bylaws Committee

a. Composition

The Bylaws Committee shall be composed of voting members who shall be Active staff members in good standing. The membership shall include the Immediate Past Chief of Staff who shall chair the committee, the Vice Chief of Staff, and other interested members in good standing. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Director of Medical Staff Services.

b. Duties of the Bylaws Committee

The Bylaws Committee shall perform the key function of Bylaws Review and Revision under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and the Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all Department Rules and Regulations, Policies and other related manuals at least annually or upon request of the Executive Committee.

6. Infection Prevention & Control Committee

a. Composition

The Chairman and voting members shall be appointed by the Chief of Staff. Members shall include:

i. Five physicians, of whom one is a specialist in Infectious Diseases and representatives from Departments of Medicine, Surgery, OB/GYN, and Pediatrics.

ii. One representative each from the Patient Care Services, Quality Improvement, Pathology, and Hospital Administration.

iii. An APP representative, who shall be a non-voting member.

iv. It may include non-voting consultants in Microbiology and other relevant Hospital services.

b. Duties

The Infection Prevention & Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of active infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, and other duties as defined in the policy manual.

c. Meetings

This committee shall meet at least quarterly, shall maintain a record of its proceedings and activities, and shall provide monthly written reports to the Quality Council Committee and the Executive Committee with regard to conclusions, recommendations, actions taken and the results of actions taken. Significant issues are presented to the Clinical Practice Improvement Teams or other Committees as needed.

d. Emergency Responsibility

The Infection Prevention & Control Committee is authorized to take steps including isolation of patients, limitation of visiting privileges, and obtaining appropriate cultures to assure maximum safety of all patients from acquired infection. This will be affected in coordination with the attending physician when possible. Otherwise, the line of authority will be as follows,

i. Chairman of Infection Prevention & Control Committee;

ii. Hospital Epidemiologist;

iii. Chief of Staff;

iv. Department Chief;

v. Chief Medical Officer and Vice President / Nursing Services

7. Health Information Management Committee

a. Composition

The Chairman and voting members shall be appointed by the Chief of Staff. The members shall include:

i. a Chairman and at least four (4) other physicians.

ii. one (1) representative each from Patient Care Services and Quality Improvement

iii. Chief Medical Informatics Officer or other representatives from administration

iv. the Director of Health Information Management

v. An APP representative, who shall be a non-voting member.

b. Duties

i. to review medical records to assure their adequacy for use in patient care evaluation and to control format and forms authorized for use in the medical record;

ii. to review medical record audit and aggregate data on the completeness, accuracy and timeliness of records by the medical staff in cooperation with nursing, HIM, management and administrative services and representatives of other departments as appropriate.

iii. to provide written reports with regard to conclusions, recommendations and action taken to the Professionalism Committee and to report the minutes from the HIM Committee to the Executive Committee.

c. Meetings

The meetings of the Health Information Management Committee shall be at least bi-monthly or as determined by the Committee Chairman.

8. Pharmacy and Therapeutics Committee

a. Composition

The Chairman and committee members shall be appointed by the Chief of Staff. All appointed committee members shall have full voting privileges. The members shall include a minimum of:

i. at least three Medical Staff members

ii. a representative of Patient Services

iii. a representative of Hospital administration

iv. a representative of Pharmaceutical Services.

b. Duties

This committee shall be responsible for the development and surveillance of all policies and practices regarding the evaluation, selection, distribution, handling, therapeutic use, and administration of drugs, diagnostic materials, and related devices. The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff for complete current knowledge on matters relating to drugs and drug use. The committee provides written reports to the Quality Council and to the Executive Committee regarding conclusions, recommendations, actions taken, and the results of actions taken. It shall also perform the following specific functions:

i. Serve in an evaluative, educational and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of drugs (including investigational drugs).

ii. Develop a formulary of drugs accepted for use in the organization and provide for its constant revision at least annually. The selection of items to be included in the formulary should be based on objective evaluation of their relative therapeutic merits, safety, and cost. The committee should minimize duplication of the same basic type, drug entity, or drug product.

iii. Establish programs and procedures that help ensure safe and effective drug therapy.

iv. Establish programs and procedures that help ensure cost-effective drug therapy.

a. Establish or plan suitable educational programs for the organization's professional staff on matters related to drug use.

b. Participate in quality-assurance activities related to distribution, administration, and use of medications.

c. Monitor and evaluate adverse drug reactions in the health-care setting and to make appropriate recommendations to prevent their occurrence.

d. Initiate or direct (or both) drug use evaluation programs and studies, review the results of such activities, and make appropriate recommendations to optimize drug use.

e. Advise the pharmacy department in the implementation of effective drug distribution and control procedures.

v. Disseminate information on its actions and approved recommendations to all organizational healthcare staff.

vi. Provides applicable information and recommendations regarding medication use to the Credentials Committee and Executive Committee for use in review, monitoring, and periodic evaluation of independent licensed practitioners.

c. Meetings

This committee shall meet at least quarterly. Written reports shall be maintained of all evaluations performed, actions taken. Written reports with regard to conclusions, recommendations, action taken and the results of action taken shall be submitted to the Quality Council and the Executive Committee.

9. Quality Committees

Members of the Medical Staff participate in performance assessment and quality improvement activities as outlined in the Florida Health Sciences Center

Performance Improvement Plan, which is approved by the Executive Committee and the Board.

10. Surgical Suite Committee

a. Composition

The Chairman shall be appointed by the Chief of Staff and the Committee shall elect a Vice-Chairman from the assigned delegates. A primary and alternate delegate will be nominated for approval by the Chief of Staff from each surgical department and section, including Anesthesiology. The delegates must be members with a strong interest in the effective and efficient utilization of the operating suites. A CRNA shall be appointed as a non-voting member. Administrative members shall be the Director of Surgical Services, Chief Medical Officer and Chief Nursing Officer. Additional ex-officio members shall be appointed by the Chief of Staff as needed.

b. Duties

i. Serves as an Advisory Committee to the Executive Committee and Hospital Administration and to administer efficient, cost effective and patient-friendly surgical suites. The Committee will serve as a forum for communication between Medical Staff, Administration and employee staff.

ii. Discuss, advise and/or act upon all suggestions and grievances submitted by any person granted operating room privileges.

iii. Receive, review and make recommendations to the Executive Committee regarding the monitoring and evaluation of the quality and appropriateness of care and treatment of patients served through the Operating Room and affiliated areas.

c. Meetings

The Surgical Suite Committee shall meet at least bi-monthly.

11. Practitioner Health Advisory Committee

a. Composition

The Medical Staff implements a process to identify and manage matters of individual health for licensed independent practitioners. This process is separate from actions taken for disciplinary purposes. The Practitioner Health Advisory Committee shall be comprised of no less than three (3) active appointees of the medical staff appointed by the Chief of Staff. Each member shall serve a two-year term and as deemed appropriate by the Chief of Staff to achieve continuity, consideration should be given when appointments are changed. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee. A Chairman shall be appointed by the Chief of Staff

b. Duties:

The Practitioner Health Advisory Committee shall:

i. Receive reports related to the health, well-being or impairment of medical staff appointees and, as it deems appropriate, in cooperation with the Florida Professional Resource Network may investigate such reports immediately.

ii. With respect to matters involving individual medical staff appointees, may in cooperation with the Professional Resource Network, on a voluntary basis, provide advice, counseling or referrals as it may determine to be appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff appointee poses an unreasonable risk or harm to patients, that information may be referred to the Chief of Staff and/or the Chief Medical Officer for corrective or administrative action.

iii. The Committee may, in its discretion, request that a practitioner voluntarily submit to an evaluation and follow any recommendations made by the treating professional, treatment staff and the staff of the Florida Professional Resource Network or similar program or health care practitioners who have treated or evaluated the practitioner. An intervention shall be conducted by the chair or their designee.

iv. If a practitioner follows this course of action following an intervention and can demonstrate to the committee that he or she is capable of caring for patients safely and competently, neither suspension of clinical privileges nor any other disciplinary action shall be taken.

v. In the event the practitioner should refuse to submit to a requested evaluation and there is a reasonable belief that the practitioner may present a danger to his or her own health or safety, or the safety of patients, the committee shall immediately refer the practitioner to any of those identified in these bylaws who are authorized to initiate a request for corrective action.

c. Meetings

The committee shall meet as often as necessary and shall maintain record of its proceedings.

d. Confidentiality

Records shall be kept on individual practitioner who is being followed by the committee. Records shall be kept locked with only the members of the committee and the Tampa General Hospital Chief Medical Officer or his/her designee having access. At no time will the identity of the practitioner nor the nature of the impairment be released to anyone other than the committee, the TGH Chief Medical Officer, or consultants, the staff of the Florida Professional Resource Network, or similar program and the persons involved in the intervention process. Records shall be kept separately from the practitioner's credentials file. The Florida Professional

Resource Network or similar program may keep concomitant files. The Florida Professional Resource Network, similar program or healthcare practitioner may provide assistance with all cases of impairment or potential impairment. Upon completion of the rehabilitation, the committee or chair shall make a recommendation concerning reinstatement.

12. Peer Review Committee

a. Composition

i. The Chairman shall be appointed by the Chief of Staff. The Chairman shall be a member with a demonstrated interest in quality and prior medical staff leadership experience. The Committee shall elect a Vice-Chairman from the assigned committee members.

ii. Members of the Active Medical Staff that represent a broad representation of Departments and Sections with voting rights.

iii. An APP representative, with voting rights on relevant APP peer review issues but without voting rights on physician peer review issues

iv. Administrative members shall be the Director, Quality Improvement, Director Risk Management, and the Chief Medical Officer. Appointed members shall serve two (2) year terms and can serve an unlimited number of terms.

b. Duties

i. Responsible for coordinating all elements of the peer review process

ii. Ensure appropriateness of clinical practice and examine significant departures from established practice.

iii. Oversee the Ongoing Professional Practice Evaluation (OPPE) to ensure the quality of care delivered by practitioners.

iv. Oversee practice remediation when practitioners fall below acceptable standards in conjunction with the Credentials Committee.

v. The Committee may, at its option, elect to meet with the practitioner and seek additional information.

vi. Refer practitioners to the Credential Committee when significant variances are noted

c. Meetings

The Committee shall meet monthly at least ten (10) times per year.

d. Quorum: A quorum of this committee shall consist of fifty percent (50%) of the voting members.

e. Attendance: The attendance requirement is fifty percent (50%). Failure to attend 50% of the meetings may result in replacement on the committee.

13. Critical Care Steering Committee

a. Composition

The Chief of Staff will in collaboration with the members of the Critical Care Steering Committee appoint a Chairman and Vice-Chairman. Appointed committee members must be members of the Active Medical Staff. Committee membership will include medical directors or representatives of all the critical care services including surgery/critical care, pulmonary/critical care, anesthesia/critical care, pediatric critical care; the medical directors of each ICU. Any physician providing critical care services may attend. Voting is limited to a single representative of each practice group and to medical directors or their designee. Administrative ex-officio members with vote shall be the Chief Operating Officer, Chief Medical Officer, VP Acute Care and Therapy Services, VP Women's & Children's Services, VP Cardiovascular & Transplant Services, and VP ER & Trauma Services.

b. Duties

i. Responsible for oversight of critical care services provided throughout Tampa General Hospital.

ii. Establish guidelines for policy and procedure development relating to critical care services.

iii. Evaluate, recommend, and establish parameters for implementation of new treatment modalities, equipment, or medications as they relate to management of critical care patients.

iv. Assure adequate resources are available for management of critical care patients as well as patients outside the critical care units who become critically ill.

v. Evaluate patient outcomes data in order to develop process improvements which will enhance both patient safety and patient experience in the ICU setting.

vi. Responsible for oversight of the Code Blue Committee which will report to the Critical Care Steering Committee on a bi-monthly basis.

vii. The Critical Care Committee reports to the Critical Care Steering Committee monthly.

viii. The Critical Care Steering Committee reports to the Quality Council.

c. Meetings

The committee shall meet monthly.

14. Trauma Program Operational Process Performance Committee

a. Composition

i. The Trauma Program Medical Director shall serve as the committee chairperson. The Orthopedic Trauma Director and the Neurosurgical Trauma Director shall serve as vice chairs and shall be nominated by their respective chiefs of service and appointed by the Trauma Program Medical Director.

ii. Appointed Members from the medical staff will include representatives from Emergency Medicine, Anesthesia, General Surgery, Orthopedic Surgery, Neurosurgery, Surgical Critical Care (adult and pediatric), Pediatric Surgery, Rehabilitation Medicine, and Radiology.

iii. Invited Members from the medical staff will include representatives from clinical specialties as the agenda requires.

iv. Appointed administrative members from the Hospital staff will include the Chief Operating Officer, Chief Medical Officer, VP ED and Trauma Services, and the Trauma Program Manager.

v. Invited members of the hospital staff will include representatives from the Aeromed Transport, TGH Transfer Center, Emergency Department, Operating Room, SICU, Trauma Unit, Radiology, Laboratory/Blood Bank, and other hospital services as the agenda requires.

b. Duties

i. Assess, address, and correct global trauma program and system issues. Review and revise trauma care processes allocation of resources.

ii. Review program policies, procedures, and statistics relative to volume, mechanism of injury, outcome, quality measures, and resource allocation to assure optimal care of the injured patient.

iii. Maintain program compliance with various trauma related regulatory agencies including the American College of Surgeons Committee on Trauma.

c. Meetings

The committee shall meet monthly, take attendance, and keep minutes. A minimum of ten meetings will be held over the course of the year.

15. Cancer Committee

a. Composition

The Chief of Staff will appoint a physician involved in cancer care to be the Chair of the Cancer Committee. The Committee shall elect a Vice Chair from the assigned committee members. Those appointed to the

Committee must include those physicians and non-physicians required by the most current Commission on Cancer Program Standards. The appointed physicians must be members of the Active Medical Staff.

At the first meeting of the year, Members will be appointed to coordinator positions for one-year terms. Appointed coordinators are responsible for specific areas of cancer program activity and compliance. An individual cannot serve in more than one coordinator role during a term.
Coordinator positions include:

Cancer Conference Coordinator
Quality Improvement Coordinator
Cancer Registry Quality Coordinator
Community Outreach Coordinator
Clinical Research Coordinator
Psychosocial Services Coordinator

Should the Chair of the Cancer Committee resign from this position then the Vice Chair will become the Chair until the Chief of Staff appoints a permanent replacement.

All identified members shall be voting members. Each appointed member must identify a substitute who meets the requirements for membership on the committee and between the two must maintain 75% attendance.

b. Duties

The Cancer Committee will follow the requirements outlined in the most current Commission on Cancer Program Standards. The Chair of the Cancer Committee will report to the Medical Executive Committee Quarterly.

c. The Cancer Committee shall:

1. Develop and evaluate the annual goals and objectives of the clinical and programmatic activities related to cancer;

2. Promote a coordinated, multidisciplinary approach to patient management;

3. Ensure that educational and consultative cancer conferences cover all major sites and related issues;

4. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;

5. Promote clinical research;

6. Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting;

7. Perform quality control of registry data;

8. Encourage data usage and regular reporting.

d. Meetings shall be held at least quarterly.

16. Professionalism Committee

a. Composition: the Professionalism Committee shall be a multidisciplinary committee consisting of clinically-active practitioners and other individuals with expertise in professionalism responsible for ensuring the practitioners practicing at Tampa General Hospital exhibit the highest standards of professionalism. The Chairman shall be the Vice Chief of Staff. The members shall include:

i. Secretary/Treasurer of the Medical Staff

ii. The Immediate Past Chief of Staff

iii. A member of the Credentials Committee appointed by the Chief of Staff

iv. A member of the Peer Review Committee appointed by the Chief of Staff

v. Chief Medical Officer or the Associate Chief Medical Officer,

vi. Chief Quality Officer

vii. the Director of APP

viii. Additional members as deemed necessary by the Chief of Staff

b. The duties of the Professionalism Committee shall be to:

i. Receive and review the validity of complaints regarding concerns about professionalism of credentialed practitioners;

ii. Provide notice to practitioners of identified verified concerns.

iii. The Committee may, at its option, elect to meet with the practitioner who is the subject of a complaint, or may designate someone to meet with the practitioner on its behalf..

iv. Treat, counsel and coach practitioners in a firm, fair and equitable manner;

v. Maintain the confidentiality of the individual who files a report/complaint unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the hospital's legal responsibility;

vi. Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards;

vii. Collaborate with the clinical department chief, the program director if the incident involves a resident or fellow, the chief medical officer or his/her designee or, if applicable, the chief nursing officer; and

viii. Report findings and recommendations to the Executive Committee.

c. Meetings: The Committee shall meet at least annually and on an as needed basis and maintain a permanent record of proceedings and actions.

17. Other Committees

In addition to the committees delineated herein, the Chief of Staff may appoint other committees to direct or monitor, review, and evaluate the quality, safety, and appropriateness of patient care as he deems appropriate. Medical Staff members shall be recommended for participation on all Hospital Committees by the Chief of Staff.

ARTICLE VIII. GENERAL MEDICAL STAFF MEETINGS

Section A. Regular Meetings

The Medical Staff Year shall be the period from October 1 – September 30 of each year. An annual staff meeting shall be held in the last month of the Medical Staff Year at a time and place designated by the Medical Executive Committee. The Chief of Staff may schedule additional regular meetings during the Medical Staff year and written notice of the meeting shall be sent to all medical staff members and a notice conspicuously posted.

Section B. Special Meetings

1. Special meetings of the Medical Staff may be called by the Chief of Staff or the Executive Committee at any time. They may also be called upon receipt of written request to the Chief of Staff signed by not less than 25 members of the Active Medical Staff and stating the reason for requesting the meeting.

2. Such special meetings must be set for not less than two (2), nor more than thirty (30) days from the date of filing of the request.

3. Notice of special meetings shall be given at least 48 hours prior to the meetings.

4. The Chief of Staff shall designate the time and place of any special meeting.

Section C. Quorum

A quorum at general Medical Staff meetings shall be those Active Medical Staff voting members present.

Section D. Attendance Requirements

Members of the Active Medical Staff and Associate Medical Staff shall be encouraged to attend the general Medical Staff meetings.

Section E. Agenda

1. The agenda of regular meetings shall be:

a. Call to order;

b. Acceptance of the minutes of the last annual meeting and of all special meetings;

c. Unfinished business;

d. Communications;

e. Report from administration;

f. Reports of clinical Departments;

g. Reports of committees;

h. New business (including elections, where appropriate); and

i. Keynote speaker as an option

j. Adjournment.

2. The agenda of special meetings shall be:

a. Reading of the notice calling the meeting;

b. Transaction of business for which the meeting was called; and

c. Adjournment.

ARTICLE IX. DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

Section A. Regular Meetings

Departments and Sections shall hold meetings at least quarterly and on the call of the Chief.

Section B. Special Meetings

A special meeting of any Department or Section or Committee may be called by the Chief, Chairman, Chief of Staff, or by one-third of the group's members, but not less than two (2) members.

Section C. Notice

Regular meetings may, by resolution, be held without notice. Special meetings require at least two (2) days' notice. Notice of time and location must be given by the Medical Staff office.

Section D. Attendance

A minimum of 50% attendance at Department and Section meetings is encouraged. Members may attend the meeting by telephone, virtually or by other electronic means. Whenever a staff or department educational program is prompted by findings of quality assessment/improvement, the practitioner whose performance prompted the program will be notified of the time, date and place of the program, the subject matter to be covered and its special applicability to the

practitioner's practice. Except in unusual circumstances, the practitioner shall be required to be present.

Section E. Quorum

Except as specified elsewhere in these Bylaws, a quorum at Committee, Department, Section, and general Medical Staff meetings shall be those Active Medical Staff voting members present. The action of a majority of committee members present at a meeting at which a quorum is present shall be the action of the committee, unless otherwise specified in these Bylaws. Notwithstanding the foregoing, votes on actions of a Department or Section may be conducted by email outside of scheduled meetings and directed to the Supervisor, Medical Staff Services for counting. A majority vote shall carry the proposed Department or Section action.

Section F. Minutes

Minutes of each meeting of a Department, Section or Committee shall be prepared and shall include documentation of discussions of patient care monitoring and evaluation of care together with resultant conclusions, recommendations and actions taken. In addition, there shall be a record of attendance and the vote taken on each matter. The minutes shall be signed by the presiding officer. Copies shall be submitted and reviewed at the next meeting in accordance with hospital and Medical Staff confidentiality policies, and, upon approval, forwarded to the Executive Committee. Each Department, Section, and committee shall maintain a central file of minutes in the Medical Staff Office.

ARTICLE X. RISK MANAGEMENT

Section A. Risk Management Activities

The Medical Staff shall participate, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

1. The identification of general areas of potential risk related to the clinical aspects of patient care and safety.

2. The development of criteria for identifying specific patient care incidents with potential risk related to the clinical aspects of patient care and safety, and recommendation for their evaluation and mitigation through corrective actions.

3. The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

4. The design of programs to reduce risk in the clinical aspects of patient care and safety.

5. The formation, testing and participation for the medical staff in an internal and external disaster plan.

ARTICLE XI. PERFORMANCE IMPROVEMENT

Section A. Performance Improvement Activities

The organized Medical Staff has a leadership role in hospital performance improvement activities to improve the quality of care, treatment and services and patient safety and shall participate, as appropriate, in the following performance improvement activities:

1. Serve as leaders/members of Clinical Practice Improvement Teams, reviewing Medical Staff issues, and participating in opportunities for improvement and reporting activities at the Department/Section meetings.

2. Participation in the peer review process as requested by Department/Section, Chief or Medical Staff Peer Review Committee.

3. Participate in the Hospital's effort to comply with standards set forth by The Joint Commission (JC), the Agency for Health Care Administration (AHCA) and Quality Improvement Organizations.

4. Providing leadership for measuring, assessing and improving processes that primarily depend on the activities of one or more licensed independent practitioners and other practitioners credentialed and privileged through the medical staff process.

5. Serve as leaders/members of Ad Hoc Committees assessing patient satisfaction, quality improvement related to morbidity and mortality, and cost per discharge.

6. Serve as leader/member of ad hoc committees appointed by the Medical Executive Committee to address quality improvement issues.

7. Support the JC mandated monitoring and evaluation activities in the areas of blood use, medication use, operative and invasive procedures, infection control, patient restraint and conscious sedation.

8. Ensure that information disseminated as part of the hospital's performance improvement efforts, e.g., Sentinel Events, Serious incidents, Joint Commission National Patient Safety Goals, clinical data submitted for public websites, is discussed and, as appropriate, incorporated into practice.

9. Ensure appropriate and efficient utilization of Hospital resources.

10. Maintain quality clinical pertinence in the medical record through documentation that is inclusive, legible, appropriate, and timely.

11. Attend Department/Section meetings to obtain specialty-specific performance improvement information generated through the quality management process.

12. Participates in the measurement, assessment and improvement of other patient care processes, including but not limited to education of patients and families and coordination of care with other practitioners and hospital staff as relevant to the care of an individual patient.

ARTICLE XII. RULES AND REGULATIONS and RELATED POLICIES/MANUALS

Section A. Rules and Regulations and Related Policies/Manuals

The Medical Staff shall recommend to the Board such Rules and Regulations and related Policies/Manuals of the Medical Staff as may be necessary to implement

more specifically the general principles found within these Bylaws. The Rules and Regulations and related policies/manuals shall relate to the proper conduct of the Medical Staff organization activities and shall embody the specific standards and levels of practice that are required of each Medical Staff member and other designated individuals who exercise clinical privileges or provide designated patient care, treatment or services in the Hospital. Appendix A provides guidance for those Advanced Practice Providers granted permission to provide patient care services.

Section B. Departmental Rules and Regulations

Each Department established under these Bylaws shall formulate and implement Rules and Regulations, which will become effective upon approval of the Medical Executive Committee. Departmental Rules and Regulations shall be consistent with these Bylaws, the Medical Staff Rules and Regulations, and established Hospital policies, procedures and manuals.

Section C. Administrative Procedures/Policies

When administrative procedures associated with processes described in the medical staff Bylaws for corrective actions, fair hearing and appeal, credentialing, privileging, and appointment are part of medical staff governance documents that supplement the Bylaws, they shall be consistent with these Bylaws and Rules and Regulations, and shall become effective upon approval of the Medical Executive Committee and the Board.

Section D. Relationship to Bylaws

In the event there is a discrepancy between these Bylaws and any such Rules and Regulations, these Bylaws shall supersede the Medical Staff Rules and Regulations and the Department/Section Rules and Regulations.

Section E. Approval

1. Approval of Medical Staff Policies or Manuals and amendments, additions, or repeal of existing Policies or Manuals shall require a simple majority of the voting members of the Medical Executive Committee present at a regular or called meeting of the Medical Executive Committee. These Medical Staff Policies or Manuals shall be a part of the Medical Staff Bylaws.

2. Appropriate sections may be amended or repealed upon the recommendation of any Department or the Executive Committee with review by the Medical Staff Bylaws Committee, and approval at any regular meeting of the Executive Committee at which a quorum is present.

3. Upon adoption by the Board, these Policies and Manuals shall be incorporated by reference and shall have the same effect as the Bylaws. Any reference to the Bylaws shall constitute reference to the Policies and Manuals as appropriate.

4. In addition to the process described above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty-five percent (25%)] of the members of the Active category. Upon presentation of such petition, the adoption process outlined in Article XIV will be followed.

5. When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party prior to vote.

6. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the MEC immediately informs the medical staff. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

7. The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

ARTICLE XIII. MEDICAL STAFF CONFIDENTIALITY AND INDEMNIFICATION

Section A. Confidentiality

1. To preserve and assure the confidentiality of all records maintained by, or on behalf of, the Tampa General Hospital Medical Staff for legal and policy purposes, the disclosure of medical staff records shall only be permitted under conditions set forth in Medical Staff and Hospital Confidentiality Policies.

2. Each practitioner will be assigned a unique password for Epic. Passwords secure an individual account on the system. Each password must be used only by the individual formally assigned to that password. Therefore, passwords must not be exchanged or shared. Failure to comply with this will result in a referral for corrective action.

Section B. Indemnification

To afford the Medical Staff members, officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Section Chiefs, and special and standing committee members who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment and performance improvement and peer review activities. The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment and performance improvement activities. Standing and ad hoc peer review members shall also be covered under the indemnity protections. Such activities shall have the following characteristics:

1. The activities such members undertake must be performed on behalf of the Hospital

2. The activities shall be performed in good faith.

3. That any professional review action shall be taken:

   a. in the reasonable belief that the action was in the furtherance of quality health care;

   b. after a reasonable effort to obtain the facts of the matter;

   c. after adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

   d. in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.

4. The activities shall follow procedures set forth in these Bylaws; Rules and Regulations, or policies;

5. Medical Staff members who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

6. The activities are extended the protections for medical review activities provided by the Florida Statutes.

ARTICLE XIV. REVIEW, AMENDMENT, ADOPTION

Section A. Review

The Medical Staff Bylaws and Medical Staff Rules and Regulations and other related Medical Staff Policies and Manuals, shall be reviewed by the Bylaws Committee annually, or at the request of the Chief of the Medical Staff.

Section B. Medical Staff Responsibility

The Medical Staff (through its Bylaws Committee and the Executive Committee) shall have initial responsibility to review, formulate, adopt and recommend to the Board, Medical Staff Bylaws and amendments, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care, treatment and services of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

Section C. Methodology

Medical Staff Bylaws must be adopted, amended or repealed by the following process after review and discussion:

1. Substantive Amendments

Proposals for substantive Bylaws Amendments must pursue one of the following sequences:

a. Option 1

i. The affirmative vote of the Bylaws Committee;

ii. The affirmative vote of the Executive Committee;

iii. The affirmative vote of two-thirds (2/3) of the Medical Staff members eligible to vote on this matter at a regular or special meeting of the Medical Staff, or if the matter is deemed urgent by the Executive Committee, the vote may be held electronically. (The proposed revised text will be submitted to the Medical Staff membership not less than thirty (30) days in advance. Upon approval, a copy of the revised Bylaws will be available to all members of the Medical Staff via the TGH portal.); and

iv. The approval of the Board, which shall not be unreasonably withheld.

b. Option 2

i. Twenty-five percent (25%) of the voting members of the Medical Staff sign a petition approving the amendment

ii. The affirmative vote of two-thirds (2/3) of the Medical Staff members eligible to vote on this matter at a regular or special meeting of the Medical Staff, or if the matter is deemed urgent by the Executive Committee, the vote may be held electronically. (The proposed revised text will be submitted to the Medical Staff membership not less than thirty (30) days in advance. Upon approval, a copy of the revised Bylaws will be available to all members of the Medical Staff via the TGH portal.); and

iii. The approval of the Board, which shall not be unreasonably withheld.

2. No Conflict with Related Documents

The Medical Staff Bylaws, Rules and Regulations and related manuals and policies shall not conflict with those of the Board.

3. Conflicts

Any conflict between the Medical Staff and the Executive Committee or the Medical Staff and the Board regarding a new or proposed change to a rule, regulation or policy shall be resolved in accordance with the applicable Medical Staff policy governing such conflicts.

Section D. Adoption

1. These Bylaws shall be adopted by 2/3 of those Active Medical Staff members present and voting at any regular or special meeting of the Medical Staff or if the matter was deemed urgent by the Executive Committee the vote may be held

electronically and shall replace any previous Bylaws, and shall become effective when approved by the Board of the Hospital. Appointments of Medical Staff Officers shall become effective on the first day of the next Medical Staff year following adoption of these Bylaws.

2. These Bylaws, together with the appended Medical Staff Rules and Regulations, and other related policies and manuals shall replace any previous documents and shall become effective when approved by the Board of the Hospital.

3. Neither the Medical Staff nor the Board may unilaterally amend these Bylaws, Rules and Regulations and other related manuals and policies.

ARTICLE XV. CREDENTIALING FOR APPOINTMENT

Section A. General Information

1. General.

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) will exercise clinical privileges in the Hospital unless and until he or she applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying for Medical Staff appointment or reappointment (or in the case of honorary, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership, he or she will comply with the responsibilities of Medical Staff membership as they exist and as they may be modified from time to time. Appointment to the Medical Staff will confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

2. Burden of Producing Information.

In connection with all applications for appointment, reappointment, or transfer in staff status, the applicant will have the burden of producing information for an adequate and thorough evaluation of his or her competence, character, ethics, ability to perform the privileges requested, and other qualifications and for resolving any doubts about such qualifications. The applicant's failure to sustain this burden will be grounds for denial of the application.

3. Appointment Authority

Appointments, denials and revocations of appointments to the Medical Staff will be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff.

4. Duration of Appointment and Reappointment

Except as otherwise provided in these Bylaws, initial appointment to the Medical Staff will be for a period of up to two (2) years. Reappointments will be for a period not to exceed two (2) years.

5. Proposed New Privileges

The Chief of each Department will review proposed new privileges with the Chief of Staff prior to the addition of the privilege to the department privileges list. The Chief of Staff will discuss the proposed privilege request with the Chief Medical Officer. They will discuss the requested new privilege with Senior Management to ensure space, equipment, staffing, and financial resources are available to support the requested new privileges. The Chief of Staff will notify the Chief of the Department of the resource availability for the requested new privilege and the site specific setting for the new privilege. Any proposed new privileges should be approved by the Credentials Committee, the MEC and the Board.

6. Gender, race, creed, age and national origin are not used in making decisions regarding the granting or denying of clinical privileges.

Section B. Application for Initial Appointment

1. Application for Appointment

The application form developed by the Professionals Credentials Committee and approved by the Executive Committee requires detailed information concerning the applicant's professional qualifications. The application form may be obtained from the Department of Medical Staff Services or downloaded from the TGH website. The application must have all sections filled out and questions answered (or accompanied by explanations for why answers are unavailable). The application will be signed by the applicant, and submitted to Medical Staff Services within six (6) months of receipt. An applicant, who has not returned the application within a six (6) month time frame, will be considered to have withdrawn the request. When an applicant requests an application form, he or she will be provided a copy of these Bylaws, the Medical Staff Rules/Regulations, Department/Section Rules and Regulations and applicable policies relating to clinical practice in the Hospital, if any.

The application form will require detailed information, which will include, but not be limited to:

a. the applicant's qualifications, including, but not limited to demographic information, professional training and experience, current licensure, current DEA registration (if applicable) board certification status and continuing medical education or continuing education information related to the clinical privileges requested by the applicant,

b. request for membership, categories, and Department/Section assignment

c. previous practice data including current and previous hospital affiliations for the past ten (10) years,

d. previously successful or currently pending professional disciplinary actions, challenges of any license, registration or DEA,

e. voluntary or involuntary relinquishment of licensure or registration or voluntary or involuntary suspension or restriction, of licensure or registration.

f. voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital,

g. non-refundable application processing fee,

h. all information provided in the application must be complete, accurate and current,

i. commencement of any formal investigation or filing of any charges, including exclusion, termination or suspension by any law enforcement agency or healthcare regulatory agency, federal or state program or government payment program.

j. the filing of any lawsuit or the asserting of any claim against practitioner alleging professional liability.

2. Application for Initial Privileges.

Each initial application for appointment to the Medical Staff as an Active or Associate staff member must contain a request for the setting- specific clinical privileges desired by the applicant. The evaluation of such requests will be based upon the applicant's education, training, experience, demonstrated competence, references, verification from primary sources, and other relevant information, including an appraisal by the clinical Department/Section in which such privileges are sought. The applicant will have the burden of establishing his qualifications and competency in the clinical privileges he requests.

a. Each clinical Department/Section will develop and define its own criteria for the recommendation of clinical privileges that reside solely within their department. The Robotics committee, a cross department committee, shall develop the privileges for robotics. For other privileges that cross departments, the Chief of Staff will appoint an ad hoc committee of representatives from each department who shall develop the criteria for the cross-department privilege. The ad hoc committee shall present their recommendation for the criteria to the Credentials Committee for its approval. Individuals who admit patients are granted setting-specific privileges to do so.

b. Privileges will be related to an individual's documented experience in categories of treatment or procedures, the results of treatment, and conclusions drawn from QI activities relevant to the individual practitioner.

c. The application form for membership with privileges will require the additional following detailed information which will include, but not be limited to: three peer references that provide an informed opinion of the applicant's current (observed within the past two (2) years) medical /clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism, and degree of incorporation of practice based learning and system based practice into the applicant's practice. At least one reference must be provided by a peer in the same specialty. References may not be 1) related to the applicant by family or marriage, 2) a recently initiated, pending or current professional partnership/financial association or 3) a former program director. It is suggested that one reference be from the department chief or similar leadership position at previous or other current affiliation.

d. request for specific clinical privileges,

e. previous practice data including current and previous hospital affiliations,

f. financial responsibility or protection pursuant to Florida Statutes 458.320(1)(a)-(c) or adequate professional liability coverage through an offshore captive insurer as identification of:

i. Malpractice insurance carrier, current and for the past five (5) years;

ii. Final judgments and/or settlements of claims for medical negligence within the past five (5) years.

g. Continuing medical education and continuing education are documented by attestation, but specific documentation may be requested for an applicant and could be considered in decisions concerning initial granting of privileges, reappointment and renewal or revision of clinical privileges,

h. attests that no health problems (physical and/or mental health) exist that could affect the ability to perform the clinical privileges requested from the Director of their Residency Programs (if recently completed) or the Chief of Staff at another hospital at which the applicant holds such privileges, or the applicant's personal physician, or a member of the Tampa General Hospital Medical Staff, or for applicants age 74.5 and older, from a physician appointed by the Medical Staff who performed physical and cognitive testing, confirming the applicant's health status to perform the requested privileges,

A query to the National Practitioner Data Bank (NPDB), Excluded Provider List (EPLS), Office of the Inspector General (OIG) and review of information received will be completed and considered on all applicants at the time of initial appointment, reappointment and at time of renewal and/or increase of clinical privileges. A criminal background check will be completed and considered on all initial applicants.

The credentialing process includes a mechanism that confirms that the individual requesting membership/privileges is the same individual identified in the credentialing documents.

3. Responsibilities of Membership

In addition to the matters set forth in this section, by applying for appointment to the Medical Staff, each applicant thereby undertakes the following obligations:

a. certifies the truthfulness of all information provided in the application,

b. signifies his or her willingness to appear for interviews in regard to the application,

c. authorizes consultation with others who have been associated with him or her who may have information bearing on his or her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information,

d. consents to the inspection for records and documents that may be material to an evaluation of his or her qualifications and abilities to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying,

e. In the event a practitioner requesting Active or Associate staff is required to undergo physical examination and/or cognitive testing, the practitioner authorizes the physician who performed the physical examinations and cognitive testing to candidly provide information bearing on his or her competence, qualifications and performance to the committee members specifically appointed for such review, and consents to the inspection of reports of the physical examination and cognitive testing by the same committee members, with the understanding that this information and these reports contain protected health information and practitioner does not otherwise consent to the review, inspection, or copying of these records.

f. releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant,

g. releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide, in good faith or without malice, information regarding the applicant, including otherwise confidential information,

h. consents to the disclosure to other hospitals, medical associations and licensing boards and to other similar organizations as required by law, any information regarding his or her professional standing or competence that the hospital, Medical Staff or any individual may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law,

i. acknowledges responsibility for the timely payment of any staff dues, assessment, or associated late fees,

j. pledges to provide for continuous quality care for his or her patients;

k. pledges to keep all information required in Article lll, current by promptly notifying the Credentials Committee in writing of any changes.

4. Applicant Adherence to Bylaws

The application form will include a statement that the applicant has received and read these Bylaws and the Medical Staff Rules and Regulations and that he or she agrees to be bound by the terms thereof, if granted membership and/or clinical privileges, and to act in accordance with the terms thereof without regard to whether or not he or she is granted membership and/or clinical privileges in all matters relating to consideration of this application.

The applicant agrees that Medical Staff privileges at Hospital are a privilege and not a right. Failure for the applicant to comply with the application process herein in any manner will invalidate the application. The application will automatically be rejected, and if clinical privileges have been granted, will be cause for Corrective Action. If the application is invalidated or rejected as provided herein, the applicant will not be entitled to any hearing or appeals rights.

Section C. Appointment Process

1. Verification of Information

a. The applicant will deliver a completed original application with required supporting documents and the application processing fee. The application and all supporting materials will be reviewed for completeness and compliance with the Threshold Qualifications for membership on the medical staff. An application will be deemed incomplete unless the applicant meets all the Threshold Qualifications.

b. The Department of Medical Staff Services will seek to expeditiously collect and verify credentials required by the Credentials Committee including references, licensure and registration status, identity, and other evidence submitted in support of the application. Verification of current licensure through the primary source internet site or by telephone is acceptable, if this verification is documented, dated and signed. If Medical Staff Services cannot obtain verification of relevant data within 60 days, Medical Staff Services will notify the applicant of his obligation to assist in completing the application process. The applicant will be notified of any problems in obtaining requested information, and it will be the applicant's obligation to facilitate the receipt of required information.

c. An application will not be considered ready for Chief review until verifications have been obtained including either a statement from a hospital that currently privileges the applicant, as a member in good standing or data from the applicant's practice review from a hospital that currently privileges the applicant or if the applicant is a recently graduated Resident, an attestation of good standing from his or her Residency/Fellowship director. An application which is deemed incomplete due to applicant inactivity, as determined by the Credentials Committee, 120 days after submission, will be considered withdrawn.

d. When collection and verification are accomplished and the application is deemed ready for review with any questions clarified, all such information will then be transmitted to the appropriate Chief of the appropriate Department and/or Section who may interview the applicant and who will review the application, request clarification on any questions, and make a recommendation to the Credentials Committee at its next regularly scheduled meeting.

e. In no instance will an appointment be made or clinical privileges awarded until basic information to verify one's training and current competence is verified. The American Medical Association Physician Profile may be used as primary source for medical school verification.

f. Licensure and DEA registration (if applicable) is verified, with primary source, at time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges and at time of expiration. Verification of current licensure through the primary source internet site or by telephone is acceptable, if this verification is documented, signed and dated.

2. Department Review

Medical Staff Services will notify the Chief of the Department/Section of the primary department which the applicant seeks privileges, within five (5) days after the application is deemed ready for review.

The Chief or Vice Chief will review the application and supporting documentation, and may conduct a personal interview with the applicant. The Chief or Vice-Chief will evaluate the professional competence of the applicant and all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and submit a written recommendation to the Credentials Committee and the Executive Committee regarding a recommendation for appointment, and if appointment is recommended, as to a membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Chief may also request that the Executive Committee defers action on the application. The recommendation should be submitted within fifteen (15) days of notice of the application deemed ready for review.

3. Credentials Committee Review

The Credentials Committee will review the evidence of the character, professional competence, ability to perform the privileges requested, qualifications and ethical standing of the applicant and determine, through information contained in references and other sources available to the Committee, including the Chief's report and recommendations, whether the applicant meets all the necessary qualifications for the category of staff membership and clinical privileges requested. The Credentials Committee may elect to interview the applicant and/or seek additional information.

a. At the next meeting, or as soon thereafter as is practical (but not to exceed 30 days), after receipt of the Department/Section recommendation and the application for membership, the Credentials Committee will submit to the Executive Committee a written report and, if appointment is recommended, as to the membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

b. The Credentials Committee will recommend the applicant be either appointed to the Medical Staff with written delineated privileges, or rejected for Medical Staff membership, or that the application is deferred for further consideration.

4. Executive Committee Action

a. No application shall be considered to be complete until it has been reviewed by the appropriate department chair, the Credentials Committee, and the Medical Executive Committee and all have determined that no further documentation or information is required to permit consideration of the application. Additional information or documentation may be requested by any department chair, by the Credentials Committee, or by the Medical Executive Committee. If the applicant fails to submit the requested information or documentation within thirty (30) calendar days after being requested to do so, the application shall be deemed incomplete and automatically withdrawn, unless the time to obtain the information is extended by the person or committee requesting the information.

b. At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Executive Committee will consider the report and any other relevant information. The Executive Committee may request additional

information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant.

i. Favorable recommendation: When the recommendation is favorable to the applicant, it will be promptly forwarded, together with supporting documentation, to the Board. All decisions to appoint will include a delineation of clinical privileges, which the practitioner may exercise.

c. Deferred recommendation: When the recommendation of the Executive Committee is to defer the application for further consideration, the Executive Committee must act upon the deferred application in a timely fashion at its next regular meeting with a subsequent recommendation for appointment with specific clinical privileges, or for rejection for staff membership.

d. Adverse recommendation: When the recommendation is adverse to the applicant relative to appointment or clinical privileges, the applicant will be promptly informed by written notice (certified mail-return receipt requested) by the Chief Executive Officer. No such adverse recommendation will be forwarded to the Board until after the practitioner has exercised, or has waived, his right to a hearing as provided for in the Hearing and Appellate Review process as provided for in these Bylaws.

e. If a hearing is requested, the Executive Committee will reconsider its recommendation following receipt of the report and recommendation of the hearing panel. If the reconsidered recommendation of the Executive Committee is favorable to the applicant, the written report will be forwarded to the CEO, for prompt transmittal to the Board, along with all documentation. The recommendation will include membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment and the reasons for each recommendation will be stated.

f. If such recommendation continues to be adverse, the CEO will immediately notify the applicant by certified mail, return receipt requested, within 15 days and the Credentials Committee. The CEO will also forward such recommendation and documentation to the Board, but the Board will not take any action thereon until after the applicant has exercised or has been deemed to have waived his rights to an Appellate Review as provided by these Bylaws.

g. Upon written application and recommendation of the Section or Department, the Executive Committee may grant an exception to the Section or Department requirement of Board admissibility/certification for a candidate uniquely qualified by training or experience.

5. Actions on the Application

The Board may accept the recommendation of the Executive Committee or may refer the matter back to the Executive Committee for further consideration, stating the purpose of such referral. The following procedure will apply with respect to action on application:

a. If the Board concurs with the recommendation of the Executive Committee the decision of the Board will be deemed final action.

b. If the Board does not concur with the recommendation of the Executive Committee, the Board will submit the matter to representatives from the Executive Committee and the Board for review and recommendation and then the Board will consider such recommendation before making its decision final.

c. If the decision is adverse, the CEO will immediately notify the applicant of such adverse decision by certified mail, return receipt requested. Such adverse decision will be held in abeyance until the applicant has exercised or has been deemed to have waived his rights under the hearing and appellate review process outlined in these Bylaws. The fact that the adverse decision is held in abeyance will not be deemed to confer privileges where none existed before.

d. At its next meeting after all the applicants' rights under the hearing and appellate review process have been exhausted or waived, the Board, or a duly authorized committee thereof, will act in the matter. The decision will be final, except that the Board may defer final determination by referring the matter to the Executive Committee for further consideration. Any such referral may state the reasons, will set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. Such issues may include:

   i. The decision or the process by which the decision was reached is contrary to these Bylaws, Medical Staff Rules and Regulations, the Hospital Bylaws, the Hospital Rules and Regulations, accreditation standards or current law;

   ii. The decision recommends clinical privileges which are beyond the scope of practice of the practitioner; or

   iii. The decision is not supported by reliable, probative or substantial evidence.

e. Modification or termination for clinical privileges will not take effect until the hearing and appeals provided in these Bylaws and requested by the member concerning the modification or termination have been completed.

6. Notice of Final Decision

a. Notice of the final decision will be sent to the applicant, with copy to the Chief of the Department/Section.

b. A decision and notice to appoint or reappointment will include, if applicable:

   i. Staff category to which the applicant is appointed,

   ii. The Department/Section to which he or she is assigned, including specific requirements of the Department/Section;

iii. The clinical privileges granted;

iv. The timeframe of the appointment; and

v. Any special conditions attached to the appointment

7. Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment will not be eligible to reapply to the Medical Staff for a period of five (5) years. Any such reapplication will be processed as an initial application, and the applicant will submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

8. Timely Processing of Application

Applications for staff appointments will be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the expectation is to have review and action by the Board within 180 days from receipt of the completed application.

Section D. Changes in Staff Categories

1. Active to Courtesy or Courtesy to Active

Any practitioner may, within reasonable standards, request a transfer to Courtesy Medical Staff or to Active Medical Staff subject to the Category requirements described in Article III, Section E. The reason for such request should be made, in writing, to the Chief of his/her Section/Department for recommendation. In the event that the change from Courtesy to Active or Associate Staff category is granted, the Department/Section Chief shall perform a Focused Professional Practice Evaluation on the member.

2. Active, Associate, or Courtesy to Honorary

Any practitioner meeting the conditions contained in the Bylaws, Article III, Section E, #4, may, upon request in writing to the Chief of Section/Department, be designated as a member of the Honorary Medical Staff. Following recommendation of the Chief of the Section/Department regarding changes in staff category in each of these categories, the procedure provided in Section B of this Article relating to recommendations on applications for initial appointment and reappointment shall be followed if a change back to active status is requested.

3. Active to Associate or Associate to Active

Any practitioner may, within reasonable standards, request a transfer to Active Medical Staff or to Associate Medical Staff subject to the Category requirements described in Article III, Section E., Categories of Medical Staff Membership. The reason for such request should be made, in writing, to the Chief of his Section/Department for his recommendation. In the event that the change from Associate to Active Staff category is granted, the Department/Section Chief shall perform a Focused Professional Practice Evaluation of the member.

ARTICLE XVI. REAPPOINTMENT AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR PRIVILEGES

Section A. Reappointment

1. Each application for reappointment to the Medical Staff for Active or Associate staff must contain a request for the setting- specific clinical privileges desired by the applicant. The evaluation of such requests will be based upon the applicant's education, training, experience, demonstrated competence, references, verification from primary sources, and other relevant information, including an appraisal by the clinical Department Section in which such privileges are sought. The applicant will have the burden of establishing his qualifications and competency in the clinical privileges he requests. A request by a member for a modification of clinical privileges may be made at any time, but such requests may require, based on the Chief's review, documentation of training and/or experience supportive of this request. Following Board approval, a focused review shall be required for each additional privilege requested.

2. Each clinical Department/Section will develop its own criteria for the recommendation of clinical privileges that reside solely within their department. For privileges that cross departments, the Credentials Committee shall define the criteria for these privileges, based on recommendations from the departments. Individuals who admit patients are granted setting-specific privileges to do so.

3. Privileges will be related to an individual's documented experience in categories of treatment or procedures, the results of treatment, and conclusions drawn from QI activities relevant to the individual practitioner. In the event that the Practitioner has insufficient quality data for the Medical Staff to review, it shall be the Practitioner's responsibility to provide quality data from other accredited facilities similar to the quality data that TGH collects and reviews.

4. Licensure is verified, with primary source, at reappointment or renewal or revision of clinical privileges and at time of expiration. Verification of current licensure through the primary source internet site or by telephone is acceptable, if this verification is documented.

5. Current DEA registration is verified, with primary source, at reappointment or renewal or revision of clinical privileges. Verification of current registration through the primary source internet site or by telephone is acceptable, if this verification is documented, signed and dated.

6. The OIG list of excluded individuals/entities is checked to verify no exclusion, termination or suspension from participation in any Federal or State healthcare or government payment programs.

7. Medical Staff reappointment may be granted for a period of time not to exceed two (2) years.

8. Medical Staff reappointments that come due while the practitioner is undergoing Corrective Action or while the practitioner is subject to Corrective Action shall be granted on a month-to-month basis until the conclusion of the Corrective Action proceedings.

Section B. Application for Reappointment

1. At least 120 days prior to the expiration date of the current staff appointment (except for Honorary Medical Staff and Medical Staff reappointments granted on a month-to-month basis as set forth in subsection 3 of this Section), a reappointment application form developed and approved by the Executive Committee, will be mailed to the member. If an application for reappointment is not received within forty-five days, written notice will be sent to the applicant advising that the application has not been received. One final notice will be sent following this advising the applicant he or she has not complied with the reappointment process and his or her voluntary resignation will be accepted at the expiration of his or her current appointment.

2. At least 45 days prior to the expiration date, (except for Medical Staff reappointments granted on a month-to-month basis as set forth in subsection 3 of this Section), each Medical Staff member will submit to the Credentials Committee the completed application form for renewal of appointment. The application for Active and Associate staff members must include a renewal or modification of clinical privileges. The applicant will have the burden of establishing his qualifications and competency in the clinical privileges he requests. The reappointment file will include all information necessary to update and evaluate the qualifications of the applicant including but not limited to:

    a. Current license information.

    b. Current DEA registration.

    c. Evidence of the applicant's board certification status.

    d. Request for membership, categories, Department/Section assignment and clinical privileges.

    e. Verification of current and previous (since last reappointment) hospital affiliations.

    f. For practitioners requesting reappointment to the Associate staff, recommendations from peers in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and departmental and/or major clinical service recommendations are part of the basis for the development of recommendations for continued membership and will include; relevant training and experience, current competence, any effects of health status on privileges being requested.

    g. An attestation that no health problems (physical and/or mental) or impairments exist that could affect his or her ability to perform the clinical privileges requested. For practitioners age 75 and older, a physical and cognitive testing should be done by a physician appointed by the Medical Staff, confirming the applicant's health status to perform the requested privileges,

    h. Professional performance, ethics and conduct.

    i. Professional judgment and relationships with other practitioners.

    j. Clinical and/or technical skills as indicated in part by the results of QI from Tampa General Hospital or other similarly accredited facilities.

k. Previously successful or currently pending professional disciplinary actions, challenges to any licensure, registration (state or DEA) or the voluntary relinquishment of licensure or registration.

l. Voluntary or involuntary relinquishment of licensure or registration (state or DEA) or review, revocation, suspension, restriction or limitation in any jurisdiction.

m. Voluntary or involuntarily termination of Medical Staff membership, or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital.

n. Participation in Medical Staff affairs including PI and QI assignments.

o. Compliance with these Bylaws, Medical Staff Rules and Regulations, including payment of all Medical Staff assessments.

p. Cooperation with Hospital personnel and general attitude toward patients, the Hospital and the public.

q. Use of Hospital facilities for his patients and /or the number and type of patients seen in consultation or admitted by the practitioner and his efficiency in treating them.

r. Involvement in professional liability actions reportable in accordance with Florida law; final judgments and/or settlements within the past two years.

s. Results of relevant Medical Staff monitoring and evaluation activities, specific instances of treatment outcomes and the results of QI activities from Tampa General Hospital or other similarly accredited facilities.

t. Relevant practitioner-specific information from the organization's performance improvement activities is compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance, judgment and clinical or technical skills.

u. Other reasonable indications of continuing professional qualifications.

v. Reasonable evidence of current ability to perform privileges requested.

w. Each applicant for reappointment will attest to his/her participation in continuing medical education activities of the type and amount required by Florida law, but specific documentation may be requested for any applicant and could be considered in decisions concerning reappointment and renewal or revision of clinical privileges.

x. All information provided in the application must be complete, accurate and correct.

A query to the National Practitioner Data Bank (NPDB), Excluded Provider List (EPLS), Office of the Inspector General (OIG) and review of information received will be completed and considered on all applicants at the time of reappointment and at time of renewal and/or increase of clinical privileges.

3. Medical Staff Reappointments Granted on a Month-to-Month Basis

When a staff member has submitted an application for reappointment and subsequently was granted reappointment on a month-to-month basis due to ongoing Corrective Action, the member does not need to reapply for appointment following each monthly reappointment. Unless withdrawn by the Practitioner, the currently on file application for reappointment shall be deemed active and pending for a period of up to two (2) years from the date the application was submitted. A check of the National Practitioner Data Bank and licensure will be done prior to each reappointment. At the end of the two (2) year period the practitioner must submit a new application for reappointment as set forth in these Bylaws.

4. Standards and Procedure for Review

When a staff member submits the first application for reappointment and every two years thereafter, or when the member submits a request for modification of staff status or clinical privileges, the member will be subject to an in-depth review generally following the procedures set forth above.

5. Department Action

The completed reappointment application file will be submitted to the Department/Section Chief/Vice-Chief for review. The written recommendation from the chief/vice-chief regarding reappointment or non-reappointment, specific clinical privileges, and staff category will be completed and submitted to the Credentials Committee within fifteen (15) days of notice. A recommendation for non-reappointment or denial of clinical privileges must be submitted with written documentation for the same.

6. Credentials Committee Action

The Credentials Committee will make written recommendation to the Executive Committee concerning the reappointment or non-reappointment of each practitioner scheduled for a periodic appraisal, including the specific clinical privileges to be granted to each practitioner reappointed for the ensuing period. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation will be stated and documented.

7. Executive Committee and Board Actions

a. The Executive Committee will make written recommendations to the Board through the CEO, concerning the reappointment or non-reappointment of each member of the Medical Staff including the specific clinical privileges to be granted to each practitioner reappointed for the ensuring period. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such will be stated.

b. Thereafter, the procedure provided above in this Section relating to recommendations for application for initial appointment will be followed.

c. In acting of matters of reappointment and staff category changes, all Medical Staff members and other practitioners and all appropriate Hospital personnel, including members of the Board and Hospital management, will be acting pursuant to the same rights, privileges and immunities and authority as provided for in these Bylaws.

8. Failure to file Reappointment Application

Failure without explanation acceptable to the Credentials Committee, to file a completed application in a timely fashion for reappointment will result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. The member will be deemed to have resigned membership in the Medical Staff and will not be afforded the procedures set forth in the hearing and appellate review process in Article XVII. The appointee who fails to complete a reappointment application, or fails to complete a reappointment application on time will be notified by certified mail.

9. Reapplication for Membership

Any individual who has resigned from the Medical Staff or whose voluntary resignation has been accepted for failure to request reappointment can reapply. The applicant will be required to complete the initial appointment process.

10. Ongoing Professional Practice Evaluation (OPPE)

The Chief of each department will conduct an ongoing evaluation of each physician with privileges in the department to assess the physician's professional performance. Ongoing professional practice evaluation will be conducted per the OPPE policy.

In addition to the ongoing professional practice evaluation, practitioners with clinical privileges regardless of age may be required at the request of the MEC to complete an annual fitness for work evaluation that addresses their physical and mental capacity to perform the privileges requested. The physical and mental exams are to be conducted by a physician who is deemed acceptable to the Credentials Committee and the Medical Executive Committee. The selected physician shall have no personal or economic connection to the practitioner, but is familiar with the clinical privileges related to that specialty. The outcome will be documented on the approved form and submitted to the Credentials Committee by the date requested. The Credentials Committee may also request an evaluation of any practitioner of any age with cause.

The physical exam is a "fitness-to-work" evaluation and must indicate that the practitioner has no physical or mental problem that may interfere with the safe and effective provision of care permitted under the privileges granted. In addition to the physical exam, a practitioner may be required to undergo proctoring of his or her clinical performance as part of the assessment of his or her capacity to perform the requested privileges. Such proctoring may be required in the absence of any previous performance concerns. The scope and duration of the proctoring shall be determined by the MEC on recommendation of the Department Chair and Credentials Committee.

11. Focused Professional Practice Evaluation (FPPE)

The Chief of a Department must perform a focused professional practice evaluation of a physician based on the findings of the physician's ongoing professional practice evaluation or to evaluate privilege-specific competency of either an appointee or any physician with newly appointed privileges. The focused professional practice evaluation can be achieved by the Chief or a designated physician within the department with appropriate privileges and without perceived conflict of interest. In the event of a real or perceived conflict of interest, an outside review shall be conducted.

The focused professional practice evaluation may include direct observation, chart review, peer-to-peer evaluation, and the review of outcomes data as it becomes available.

The length of time of the focused professional practice evaluation will be determined by the Chief to ensure privilege-specific competency. The length of time of the review will take into consideration the number of procedures required by department rules to meet competence standards. The results of a focused professional practice evaluation will be communicated to the medical staff member or appointee. The results of the review will be placed in their medical staff Quality file. The results will indicate privilege-specific competency noted or not noted. For those reviews with a recommendation of privilege-specific competency not noted, the Chief can have an educational and/or mentoring plan as part of the summary of the review. The determined need for a focused professional practice evaluation based on data observed from an ongoing professional practice evaluation will be the Chiefs of the Department/Section judgment that the physician's professional practice or outcomes might not meet that of his department peers and the medical staff member will not have fair hearing privileges regarding the need for such an evaluation.

Except for a focused professional practice evaluation based on a request for new privileges, the initiation of a focused professional practice evaluation and the results of such professional practice evaluation shall be communicated to the Credentials Committee.

Section C. Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the chief of staff or designee, may grant temporary privileges. Temporary privileges may be granted only in the following circumstance: to fulfill an important patient care, treatment, and service need, or when an application for new privileges with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the applicant for medical staff membership and/or new privileges is waiting for review and recommendation by the MEC and approval by the Board. Additionally, the application must meet the criteria for clean application as defined below:

- All blanks and check boxes are complete,
- There are no gaps in time (training or employment) from graduation of medical/dental school,
- All primary source verifications/references have been returned and all questions are fully answered.
- There are no malpractice cases of concern,
- There are no previous or pending hospital or organization actions,
- FSMB reveals no derogatory information,
- There are no previous or pending licensing or registration actions that require investigation,
- The delineation of privileges form has been reviewed by the department/section chief(s),

- All training has been primary source verified and there are no concerns raised or negative responses,
- NPDB queried and no adverse information of concern,
- OIG database checked and no exclusions, terminations or suspensions from participation,
- All references respond "excellent" or "good"
- There are no health concerns that warrant complete investigation
- All questions have been clarified and there is sufficient information attesting to the applicant's current professional competence to perform the privileges requested and character to enable a thorough evaluation.
- No subjection to involuntary termination of medical staff membership at another organization.
- No subjection to involuntary limitation, reduction, denial or loss of clinical privileges.

Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the chief of staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

Section D. Emergency Privileges

Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

Section E. DISASTER PRIVILEGES

Disaster privileging has the following process:

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital ID card that clearly identifies professional designation;
- A current license to practice;
- Primary source verification of the license;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
- Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

c. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

d. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

e. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

f. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate

disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section F. TELEMEDICINE PRIVILEGES

Telemedicine practitioners will be credentialed using the same credentialing process as the Medical Staff or pursuant to an agreement with a distant-site entity in compliance with The Joint Commission Standards. Telemedicine practitioners will be granted privileges but not membership on the Medical Staff.

Section G. EXPEDITED CREDENTIALING PROCESS

An expedited review and approval process may be used for initial appointment. A completed application that does not raise concerns, as defined in the clean application for temporary privileges, is eligible. If the application meets the criteria for a "clean application", applicants will be granted medical staff membership and/or privileges after review and action by the following: Department Chief, Chair of the Credentials Committee acting on behalf of the credentials committee, the MEC and a Board committee consisting of at least two individuals.

Section H. Protection from Liability

In matters relating to the inquiry of, and/or the granting, restriction, suspension or termination of clinical privileges, the CEO, all persons serving on a duly appointed committee, as provided for in these Bylaws, and all persons furnishing information to the CEO and/or such committee will be deemed to be a medical review committee and immune from suit for damages as provided by Florida law, so long as no intentional fraud is committed by such person.

ARTICLE XVII. CORRECTIVE ACTION

Corrective Action consists of one of several actions that affect a licensed independent practitioner's status: Disciplinary, Temporary Medical Records Suspension, Summary Action, Summary Suspension, Medical Staff Assessment Suspension, Professional Liability Suspension, and Automatic Suspensions. Restoration or revocation of Medical Staff privileges terminates Corrective Action. Any appearance of conflict of interest will be resolved by the Medical Staff leadership. Any Corrective Action that is based on the competence or professional conduct of a Practitioner and which adversely affects the clinical privileges of a Practitioner for a period longer than thirty (30) days shall be reported to the National Practitioner Data Bank and/or any state agency as required by law.

Section A. Informal Corrective Action

Actions taken by the Medical Staff Officers, Professionalism and Peer Review Committees to counsel, educate, issue letters of warning or censure, or conduct focused professional practice evaluation (FPPE) in accordance with Bylaws, in the course of carrying out their duties, are not considered formal corrective actions. Those actions shall be reported to the Medical Executive Committee but do not require its approval. Any such actions may be communicated orally or in writing to the practitioner. The practitioner shall be given an opportunity to respond in writing. Any such actions will be documented in the practitioner's file. Such actions may not result in any restriction of privileges or membership and are therefore not grounds for any hearing or appeal under the Bylaws.

Section B. Formal Corrective Action

1. Initiation:

a. Formal Corrective Action may be initiated after receipt of a written report that alleges that a Practitioner has failed to complete certain stipulations outlined under the Physician's Disruptive Behavior Policy, or that a Practitioner's activities, statements, demeanor or professional conduct either within or outside the Hospital create a reasonable concern

i. for patient safety,

ii. for quality of patient care,

iii. for clinical competence of any Practitioner,

iv. or that such behavior creates a risk of injury or damage to any patient, employee or person present in the Hospital or to the Hospital

b. Grounds for Corrective Action shall include, but not be limited to, the following:

i. Any action or conduct of a Practitioner that creates a reasonable concern for the health and/or safety of patients, employees, or other persons at the hospital,

ii. a Practitioner engages in clinical activities outside the scope of the practitioner's approved clinical privileges,

iii. the Practitioner refuses to submit to evaluation or testing relating to the Practitioner's mental or physical status, including refusal to submit to any testing relating to drug or alcohol use, when there is a reasonable suspicion that the Practitioner's mental or physical status creates a risk of injury or harm to patients, employees, or other persons at the hospital, following a request for such evaluation or testing from the Chief of their department, the Chair of the Practitioner Health Advisory Committee or the Chief of the Medical Staff

iv. about known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, policies, rules or regulations of the Hospital or the Board or the Medical Staff,

v. about behavior or conduct by any Practitioner that is disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others, (See also policies and procedures for disruptive physicians)

vi. that the Practitioner who has been determined previously to be impaired does not comply with the course of action as set forth by these Bylaws or by the Practitioner Health Issues Policy dealing with impaired practitioners.

vii. that the Practitioner has had any medical staff membership, clinical privileges, certification, licensure or registration terminated, suspended, restricted, limited, reduced or modified in

any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges while under investigation or to avoid an investigation.

viii. a Practitioner abandons a patient or wrongfully fails or refuses to provide care to a patient,

ix. it is determined that the practitioner made a material misstatement or omission on any pre-application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or the Hospital,

x. that the Practitioner has falsified or inappropriately destroyed or altered any medical record,

xi. a Practitioner is convicted of, or enters a plea of guilty or nolo contendere, to a crime which relates to the practice of medicine or to the ability to practice his or her profession.

c. Any of the following responsible leadership may initiate or receive a signed letter of concern about a practitioner. Said responsible leadership must sign a request and submit the letter of concern to the Executive Committee to initiate the Formal Corrective Action process:

i. Any Officer of the Medical Staff,

ii. The Chief of any Department,

iii. The Chairman of any standing committee of the Medical Staff,

iv. The Chief Executive Office; or

v. Any member of the Board

vi. Chief Medical Officer or Associate Chief Medical Officer

2. Letter of Concern format:

To qualify as a letter of concern for Corrective Action, the request:

a. must be in writing, addressed to the Executive Committee directly or via the Chief of Staff, must be supported by specific activities or conduct which constitute the grounds for Corrective Action

b. must state how the perceived issue(s) meet one or more of the categories as outlined above,

c. must be signed by at least one person and include contact information for that person(s) (s); and

d. must disclose any potential conflict of interest or litigation that may be construed as bias lest the signer also becomes subject to Corrective Action.

3. Investigative Procedure:

a. The letter of concern will be presented in closed session at the next scheduled Executive Committee meeting, but not more than 35 calendar days from the date of receipt of the letter of concern.

b. The letter of concern is to be dated or date-stamped on the day received in the Medical Staff Office and such date will be the date of the letter of concern. If the letter of concern is received by qualified initiators in Section A.1.b, outside of the Medical Staff Office, it is to be dated in writing on the date of receipt and is to be forwarded for inclusion in the closed session agenda of the next scheduled Executive Committee meeting.

c. If the Executive Committee believes that a reasonable basis exists to question a practitioner's activities, statements, demeanor, or professional conduct, the Executive Committee shall by majority vote make a formal recommendation for Corrective Action and authorize the formation of an Investigative Committee to investigate the Practitioner. If no reasonable basis for Corrective Action exists, the Executive Committee shall dispose of the letter of concern.

d. The Chief of the Medical Staff shall appoint the Investigative Committee. The Investigative Committee shall be comprised of not less than three (3) and not more than five (5) Active Medical Staff members of the Investigative Panel who were not involved in the request for the investigation and who made such attestation in writing pursuant to Section A.2. above prior to participating in Investigative Committee deliberations. In the event that the Investigative Panel does not have at least (3) members eligible to participate, the Chief of the Medical Staff can appoint any member of the Active Medical Staff who otherwise meets the criteria.

i. The Chairperson shall be appointed by the Chief of Staff (or Acting Chief of Staff when necessary).

ii. Such committee shall meet within 35 calendar days of the Executive Committee's decision.

iii. During investigation the Investigative Committee is to:

a. review the letter of concern,

b. interview the letter of concern author(s) and, where indicated, others with direct knowledge bearing on the allegation

c. review pertinent medical records, Practitioner's file, and other documentary evidence,

d. interview the Practitioner under investigation and inform the Practitioner of the general nature of the investigation,

(A sample “Notice of Investigation” form is attached as Exhibit 1)

e. invite the Practitioner to discuss, explain, and/or refute the matters under investigation; and

f. conclude its investigation out of the presence of the author(s) of the letter of concern and the Practitioner and designate a person to prepare a written response to the letter of concern, which shall include a summary of all interviews with the Practitioner and all others interviewed with information pertinent to the matters under investigation.

iv. Such designated person will generate a written response within 15 calendar days of the conclusion of the investigation.

v. The written response of the Investigative Committee shall make one of the following Corrective Action recommendations to the Executive Committee:

a. dismissal of the letter of concern with no mention on the Practitioner’s permanent record,

b. oral reprimand with annotation of same on the Practitioner’s record for a period of two (2) years, after which the annotation is to be removed unless another similar event occurs (similarity to be determined by the Executive Committee in closed session),

c. a letter of warning or reprimand to the Practitioner that remains a part of the Practitioner’s permanent record for five (5) years after which the annotation is to be removed unless another similar event occurs (similarity to be determined by the Executive Committee in closed session),

d. a period of probation upon stated terms of limitation, monitoring, supervision, re-education, or other corrective management, permanently attached to the Practitioner’s record. At the end of said period, the Credentials Committee is to determine by report from the Practitioner and monitors what privileges the Practitioner may resume and make recommendation to Executive Committee and the Board. See Section A.5, below.

e. a requirement for a defined period of consultation with, or supervision by, specified Practitioners or others in the care of patients, permanently attached to the Practitioner’s record. At the end of said period, the Credentials Committee is to determine by report from the Practitioner and monitors what privileges the Practitioner may resume and make recommendation to the Executive Committee and the Board. See Section A.5, below.

f. a leave of absence upon stated terms of re-education, disorder treatment or other supervision, permanently attached to the Practitioner's record. At the end of said period, the Credentials Committee is to determine after a report from the Practitioner and other appropriate persons what privileges the Practitioner may resume and make recommendation to Executive Committee and the Board. See Section A.5., below.

g. reduction, suspension, or revocation of some specified or all clinical privileges, permanently attached to the Practitioner's record. The Practitioner may not re-apply for said privileges for up to five (5) years and may then do so through the Credentials application process. See Section A.5., below.

h. termination or suspension of staff privileges, permanently attached to the Practitioner's record. The Practitioner may not re-apply for said privileges for a minimum of five (5) years and may then do so through the initial application process, See Section A.5., below.

i. A fine up to $1,000 per occurrence. Not to exceed more than four (4) occurrences a year. The funds are to be placed in the Medical Staff Activities fund.

j. any combination of the above, but not limited to the above (permanently attached to the Practitioner's record) See Section A.5., below.

vi. Written Response of the Investigative Committee shall:

a. summarize the written report allegations,

b. list the persons interviewed including the Practitioner,

c. summarize the information received,

d. make a Corrective Action recommendation,

e. briefly explain the basis of the decision,

f. be signed by all members present at the investigative committee meeting.

g. include the Conflict of Interest Disclosure Statement (as described in Section a.2. above). It is the responsibility of the Chief of Staff and Investigative Committee Chair to reasonably discover potential conflicts of interest prior to the Investigative Committee meeting.

h. The original copy of the written response of the Investigative Committee will be forwarded to the Chief of Staff (or Acting Chief of Staff) not more than 15 Calendar days from the time all required signatures have been

obtained on the written response and it is, therefore, complete for presentation at the next Executive Committee in closed session, which must occur within 35 calendar days of completion of the Investigative Committee's written response. The Chief of Staff will promptly notify the CEO of all written reports and written response to keep the CEO appraised in a timely fashion of all subsequent actions in reference to any written report.

i. The Chief of Staff or the designee of the Chief of Staff will review the written response to assure that its format meets the requirements set forth in this Section A.3.d.5.

4. Executive Committee Response:

In closed session, the Executive Committee will discuss the letter of concern and the written response of the Investigative Committee within 35 days of completion of the Investigative Committee's written response. After a full discussion, the Executive Committee has the following alternatives:

a. by majority vote, accept the written response and the Corrective Action recommendations of the Investigative Committee unaltered,

b. by majority vote, the Executive Committee may vote to terminate the process without adopting the recommended Corrective Action,

c. by majority vote, accept the written response and alter the Corrective Action recommendations of the Investigative Committee thereafter sending the Corrective Action recommendations back to the Investigative Committee for concurrence or difference. The Investigative Committee must meet within 15 business week days of the Medical Executive Committee determination to consider and deliberate the alterations requested by the Executive Committee.

i. In the event of concurrence, the written response and the Corrective Action recommendations become final recommendations.

ii. In the event of non-concurrence, the Investigative Committee designates one or more of its members to attend the next Executive Committee closed session to discuss its views with the Executive Committee (to be held no less than 35 calendar days from the last Executive Committee). After a full discussion, the Executive Committee, by majority vote in the absence of the Investigative Committee, will make a final recommendation.

d. Such final recommendations shall be forwarded to the Chief Executive Officer ("CEO") of the Florida Health Sciences Center within five (5) working days.

e. The CEO must within fifteen (15) business days of the decision of the Executive Committee inform the Practitioner in writing of the recommendation. In the event the recommendation is adverse, the CEO must inform the practitioner of the reasons for such recommendation, the

Practitioner's rights under the Bylaws to request a fair hearing within 30 days and a summary of the Practitioner's rights during such hearing. The CEO must simultaneously notify the Board of the Florida Health Sciences Center of any adverse recommendation. A copy of the letter from the CEO will be sent to the Chief of Staff and will be attached to the Practitioner's permanent file as described above.

5. Practitioner Response and Rights to Fair Hearing:

a. The Practitioner has 30 calendar days from the date of certified receipt of notification from the CEO in which to request a hearing, if a hearing is appropriate pursuant to Article XVII.B.1. The request must be submitted in writing to the CEO and/or Chief of Staff. If no request for a fair hearing is received in the Medical Staff Office within 30 calendar days, the final recommendation becomes tentatively effective on the 31st day at 7:00 am. If the practitioner refuses to sign for the letter or seems unable to be located, a second attempt to deliver the letter by courier or certified mail addressed to the practitioner's last known address may be signed by the courier indicating the date of attempted delivery. The signature of the courier will serve as adequate effort to serve notice to the practitioner.

b. Final Recommendation Effective Date: Except for summary suspension or failure to request a fair hearing in a timely fashion, no clinical or staff privileges shall be terminated, revoked, suspended, or reduced without the concurrence of the Board after giving the Practitioner the right to a fair hearing. While implementation of the final recommendation is effective pursuant to this section, the final recommendation is not formally effective until acknowledged by the Board. A copy of the written response and any attachments shall be made available to the Practitioner by the Chief of Staff (or Acting Chief of Staff) or designee.

Section C. Summary Actions and Summary Suspension

1. Criteria and Initiation

a. A summary action or suspension may be taken whenever a Practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of imminent injury or damage to the health or safety of any patient, employee, or other person present in the Hospital. There must be:

i. a reasonable belief that the action is in the furtherance of quality health care,

ii. a reasonable effort to obtain the facts of the matter, and

iii. the reasonable belief that the action is warranted before initiating any such summary action or suspension.

b. The following persons or their designated representatives shall have the authority to summarily suspend the Medical Staff membership or summarily suspend or restrict all or any portion of the clinical privileges of such Practitioner:

i. The Chief of the Medical Staff or Acting Chief; or

ii. Chief of the Practitioner's Department

c. The summary action may include; requiring a mandatory second opinion, requiring mandatory consultation, or requiring mandatory supervision. A summary action shall be implemented with a time limit, and such time limit shall not exceed one year.

d. A summary suspension may include the suspension of Medical Staff membership, all clinical privileges or a suspension of any portion of the clinical privileges. A summary suspension that includes a suspensions of all clinical privileges will result in a suspension of EPIC access. A summary suspension shall remain in effect until a final determination is made according to the terms of these Bylaws.

2. Format of Summary Notice:

a. The person initiating the summary action or suspension must outline in writing the activities or conduct responsible for the summary action/suspension. The notice shall include: specific incidents, dates and times the activity or conduct occurred, and if available, any relevant patient medical record numbers.

b. The notice must contain the Conflict of Interest Disclosure Statement and the signer must disclose any potential conflicts of interest.

c. The format of the notice must inform the Practitioner of his or her rights under these Bylaws to request a fair hearing within 30 days and a summary of the Practitioner's rights during such hearing.

d. A sample "Notice of Summary Suspension" Form is attached as Exhibit 2 and a sample "Notice of Summary Action" Form is attached as Exhibit 3.

3. Effective Date of Notice

a. A summary action or summary suspension shall be immediately effective upon imposition.

b. The person imposing the summary action or suspension shall promptly give notice to the following individuals in the manner outlined above in Section B.2.

i. Within one business day to the Practitioner at a minimum by courier and, if possible, in person.

ii. Within 72 hours by phone or email:

a. The Chief of the Medical Staff

b. The Chief Executive Officer

c. The Chief of the Practitioner's Department

d. The Chair of the Credentials Committee

e. The Chief Medical Officer

f. The Chair of the Board of Directors of the Florida Health Sciences Center.

4. Assignment of Practitioner's Patients:

a. If clinical privileges are summarily suspended, the suspended Practitioner's patients then in the Hospital must be assigned to another Practitioner by the Department Chair or designee deemed appropriate by the Chief of Staff or Acting Chief of Staff.

b. The re-assignment of patients must consider the wishes of the patient when feasible in choosing a substitute practitioner.

5. Report of Summary Action or Summary Suspension

a. Following the summary action or summary suspension, the Chief of the Medical Staff and/or his or her designee, shall investigate the allegations which led to the summary action or suspension. The investigation into the allegations shall include:

i. reviewing any written reports or complaints,

ii. interviewing those with direct knowledge bearing on the allegation(s),

iii. reviewing the pertinent medical records, or having the pertinent medical records reviewed and interviewing the reviewer and/or reading the reviewer's written report

iv. reviewing the Practitioner's file,

v. reviewing any other documentary evidence, and

vi. conducting further investigation as indicated.

b. At the conclusion of the investigation, the Chief of the Medical Staff or his or her representative, shall prepare a written report, which shall include:

i. a list of specific allegations

ii. the evidence presented in support of each allegation.

a. If written evidence exists, copies of the supporting documents should be attached to the written report.

b. If evidence is testimonial, a signed statement from each witness describing the incident in detail should be attached to the written report.

iii. a written summary of all interviews with the Practitioner and all others interviewed with information pertinent to the matters under investigation.

iv. a list of medical records that have been reviewed, signed by the reviewer, with summaries of the pertinent records.

6. The Practitioner under summary action or suspension will be afforded an opportunity to meet with the MEC, or a subgroup thereof, as soon as possible after imposition of the summary act. Any such meeting will be informally held and the Practitioner shall not be entitled to the procedural rights associated with the Hearing and Appellate Review provided in Article XVII.

7. Procedural Rights

   a. Summary action or suspension shall be reviewed by the Executive Committee at the next meeting in closed session, which review must take place within fourteen (14) calendar days of the summary suspension. The Executive Committee may modify, continue, or terminate the summary action or suspension upon such review.

   b. Unless the Executive Committee recommends terminating the summary action or reinstatement of the suspended Practitioner, the summary action or summary suspension shall remain in effect pending Hearing and Appellate Review as per procedural rights provided in Article XVII.

   c. The Practitioner may request a hearing by a Professional Review Committee within 30 calendar days of notice of summary action or suspension. If no request for a Hearing is received within 30 calendar days, the summary action or suspension and its specified limitations are final and not able to be appealed.

   d. The formal request for a hearing by a Professional Review Committee must reference the specific summary action or summary suspension letter, must be in writing, and must be delivered to the Chief of Staff or the Chief Executive Officer of the Florida Health Sciences Center within 30 calendar days of the summary action or summary suspension date of delivery on the certified notice.

Section D. Medical Records Automatic Suspension

1. Delinquent Records. As set out in the Medical Staff Rules and Regulations should a member of the Medical Staff fail to complete assigned medical records within the allowable timeframes, all or a subset of the Practitioner's privileges shall be suspended until all of the Practitioner's available delinquent records have been completed. In addition, the Practitioner's Epic access may be suspended. The practitioner will be provided written electronic notice of the suspension. The Practitioner suspended for failure to complete assigned medical records shall not be entitled to procedural rights as outlined in these Bylaws

2. Each medical record violation shall result in the Practitioner's status being referred to the Professionalism Committee for review. The Professionalism Committee may:

   a. In the absence of a pattern of medical record violations, send a letter (return receipt requested) of warning to the Practitioner indicating that further Medical Records Suspension may adversely affect privileges at the Hospital. The letter must include the information in the Medical Records Suspension portion of Corrective Action of these Bylaws.

b. Excuse the Practitioner for reasons such as but not limited to illness, vacation, sabbatical leave, or other factor that makes the Practitioner unavailable for an appropriate period of time.

c. Send a letter (return receipt requested) to the practitioner continuing the Medical Records Suspension until the Practitioner appears before the Professionalism Committee assuring that records will be completed in a timely fashion. Each week of continued suspension shall count as an additional Medical Records Suspension episode.

d. When a Practitioner has a repeated violation history, the Professionalism Committee may take Information Corrective Action or recommend the Executive Committee take Corrective Action.

3. The Executive Committee shall review a Practitioner's record when requested by the Professionalism Committee and may:

a. Mandate (by letter return receipt requested) an interview of the Practitioner in closed session.

b. Reprimand the Practitioner and continue a period of monitoring for a period of time specified by the Executive Committee. Upon completion of the period of monitoring, the Practitioner will return to Professionalism Committee for review and possible ending of monitoring. If further Medical Records Suspension events have occurred during the period of monitoring, the Professionalism Committee may deliberate and decide whether to continue or terminate monitoring or to refer the Practitioner back to the Executive Committee.

c. Mandate that, at the Practitioner's expense, a Professionalism Committee approved health care practitioner (advanced practice or physician) complete all medical records, except that the Practitioner must be responsible for dictation of all procedure notes and for all necessary signatures.

d. Recommend corrective action pursuant to Article XVII, including the option to recommend revocation of the Practitioner's Medical Staff membership for a minimum of two years before the Practitioner may re-apply for membership to the Medical Staff.

4. If a Practitioner has a history of Medical Records violations or has outstanding Medical Records violations at the time membership or privileges are up for renewal at the hospital, the Credentials Committee shall consider that information when making its recommendations for renewal. Such violations may result in a recommendation from the Credentials Committee to deny the request for reappointment or to limit the period of time of the reappointment period.

Section E. Medical Staff Assessment

1. Medical Staff assessments are mailed at reappointment time as part of the reappointment packet. This includes reappointment processing fee and dues assessment. Payment of and any associated late fees must be submitted with the reappointment application in order to proceed with the reappointment process.

2. Medical Staff reappointment assessment fees and related late fees shall be governed by the most recent recommendation of the Medical Executive Committee. The Medical Staff shall be notified of the same in writing and advised of the same at the next annual staff meeting.

3. Failure to pay Medical Staff Assessment dues and associated late fees shall be recorded in the Practitioner's file as voluntary resignation from the Medical Staff, dues not paid, dated and signed by Medical Staff Services personnel.

4. Notice that a Practitioner has been placed on voluntary resignation from the Medical Staff, dues not paid status shall be forwarded to the Credentials Committee, the Executive Committee, the Board, and the Chief Medical Officer along with notice of action of other Practitioners.

5. Honorary staff members will not be required to pay any dues or assessments.

Section F. Automatic Suspension, Probation, Medical Staff Membership Termination

1. The Medical Staff membership and clinical privileges of a Practitioner or advanced practice provider shall automatically and without prior notice or hearing be suspended should any of the following occur:

   a. the Department of Professional and Business Regulation revokes, or suspends the professional license of a member of the Medical Staff,

   b. the US Drug Enforcement Agency revokes, or suspends a member's DEA number,

   c. a Practitioner's license be allowed to lapse,

   d. a Practitioner confesses to, convicted of, or pleads no contest to a felony, related to healthcare such as any felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child, elder or other).

   e. if the Department of Professional and Business Regulation or the US Drug Enforcement Agency reduces the professional license or controlled substance prescription-writing privileges, Medical Staff clinical privileges shall be automatically reduced in like manner pending review by the Credentials Committee and the Executive Committee as defined below.

   f. a practitioner is excluded, terminated or suspended from participation in any state or federal healthcare program, including the Medicare and Medicaid programs.

2. In the event that the Department of Professional and Business Regulation or other regulatory agency(ies) place a Practitioner on probation, reduces, or otherwise alters the level of practice, said probation shall be considered for action by the Credentials Committee at its next session. Credentials Committee shall make recommendation to the Executive Committee for action on an individual basis. The Practitioner's privileges shall be automatically suspended until the Credentials Committee and the Committee determine otherwise.

3. A Practitioner or Advanced Practice Provider that has been suspended or placed on probation may seek to have Medical Staff privileges reinstated after a time

specified by regulatory agency and/or the Hospital. The Practitioner may file a written petition for reinstatement to the Credentials Committee subject to review by the Executive Committee in closed session. The petition shall be made under oath of veracity before a notary public, shall state that the disability or issue that prompted the adverse action no longer exists and/or has been managed in a manner prescribed by the regulatory agency and/or Hospital. The petition must have appropriate supporting documentation and evidence. The Credentials Committee shall review the petition and documentation within 30 calendar days after receipt of all pertinent information by the Medical Staff office. The Executive Committee shall review the petition and documentation within another 30 Calendar days after the Credentials Committee determines that all pertinent information has been received and after the Credentials Committee has made its recommendation. Until reinstatement has been granted, the Practitioner or advance practice provider shall maintain the disciplinary status. When the Executive Committee recommends reinstatement, the Practitioner shall be notified in writing by the Chief of Staff and the Chief Executive Office by certified mail, return receipt requested or by delivering said notice in person.

Section G. Professional Liability Insurance

When information is received by the Medical Staff Office that a Practitioner no longer meets the threshold requirements as set forth in Article III, Section B.1.d of these bylaws:

1. Failure to meet the threshold financial responsibility requirements as set forth in Article III, Section B.1.d. at any time shall initially be cause for placement temporarily on automatic suspension of Medical Staff privileges.

2. Under the signature of the Chief of Staff and the CEO, the Medical Staff office shall within 15 calendar days send by certified mail, return receipt requested a notice of temporarily imposed automatic suspension of privileges, pending resolution of the liability coverage questions. The Medical Staff Office letter shall request that the Practitioner respond within 15 calendar days with clarification of and information concerning the change in the Practitioner's financial responsibility arrangement and documentation of any new financial responsibility arrangement prior to reinstatement of privileges.

3. The Medical Staff Office, by copy of notice to the Practitioner, shall also notify the Chair of the Credentials Committee, and the Chief Medical Officer of the Hospital (who shall notify the Risk Manager of the Hospital and appropriate areas of the Hospital of temporary cessation of privileges, no cause is to be written or given)

4. Response by the Practitioner to the request for information must be made in writing to the Medical Staff Office within 15 calendar days of the documented receipt of the request, as evidenced by the return receipt.

5. Temporary suspension: If the Practitioner fails to respond within 15 calendar days of receipt of the request for information, the Practitioner's privileges suspension shall be notified through the Credentials Committee to the Executive Committee and the Board and all appropriate areas of the Hospital.

6. When new insurance endorsement is received,

a. if the financial responsibility arrangement meets Hospital requirements and contains no new constraints on the privileges of the Practitioner, the Practitioner may be re-instated by the Chief of Staff.

b. if the Practitioner's financial responsibility arrangement represents coverage that places new constraints on the privileges of the Practitioner, the Practitioner must revise his or her request for privileges into a request that complies with the new constraints. The Practitioner must request reinstatement under the new set of privileges through the Credentials Committee.

7. Automatic termination of membership occurs if no new financial responsibility information is received by the Medical Staff Office within 60 calendar days from the time the Practitioner receives a request for new financial information. This information shall be conveyed in writing by the Medical Staff Office to the Chief of Staff, the Chair of the Credentials Committee, and the Chief Medical Officer. The Executive Committee and the Board shall receive such notice as part of usual process for credentialing activities.

8. A suspension or revocation based solely on a Practitioner's failure to meet the threshold liability coverage requirements as set forth in Article III, Section B.1.d shall be considered an administrative suspension/revocation and shall not entitle the Practitioner to the procedural rights as outlined in these bylaws.

Section H. Monitors, Supervisors, and Consultants

If a Practitioner has been placed under restrictions, the assigned Monitors, Supervisors, and Consultants:

1. are physician members of the Active medical staff appointed by the Chief of the Medical Staff in consultation with the Practitioner's Section/Department Chief with due consideration of the physician's availability and willingness to accept the duties and responsibilities and to the extent practicable not be from the practitioners group or practice entity in order to assure avoidance of any perception or allegation of conflict of interest or extramural pressures being placed on the monitoring physician or consultant,

2. Monitors, supervisors and consultants may be entitled to compensation at fair market value for time expended at a rate related to their specific discipline: such fee to be the responsibility of and paid by the Practitioner in an independent agreement with the designated monitor, supervisor, or consultant,

3. can only be assigned if said Monitors, Supervisors, and Consultants agree in writing to the period of service and terms and conditions, if any from a disciplinary body, or the medical executive committee outlined in writing in the notice to the practitioner,

4. must give periodic reports, as required by the terms and conditions, to the Practitioner's Section/Department Chief, with copy to the Chair of the Credentials Committee and such other specified agencies as may be required by Corrective action,

5. may resign with not less than thirty (30) days advance notice, if practicable, for personal and/or professional reason by notifying the Practitioner's Section/Department Chief and the Chief of Staff in writing, delivered in person or

by certified mail, return receipt requested, with a copy to the Medical Staff Office and the Chief Medical Officer of the Hospital. The resigning Monitor, Supervisor, or Consultant may be asked to make a personal appearance at Credentials Committee and/or the Executive Committee for a final report.

6. must give a final report to the Practitioner's Section/Department Chief and Credentials Committee in writing or by personal appearance when the assigned period of Corrective action is complete upon the request of the Practitioner for reinstatement to full and unrestricted privileges of the medical staff or alternatively if a recommendation for further monitoring or supervision is applicable; and

7. in the event of resignation from the supervision of a Practitioner, shall be replaced by a successor appointed by the Credentials Committee. If the Credentials Committee fails to find a successor, the Executive Committee may then make such reasonable adjustments in the Practitioner's supervision as it deems appropriate and submit the altered plan to the Board for its approval.

Section I. Resolution of Corrective probation, mandatory supervision, mandatory consultation or leave of absence or termination of Medical Staff membership.

1. If a Practitioner has been placed on probation, mandatory supervision, mandatory consultation, and/or leave of absence as described in this Bylaws, whether uncontested or by Executive Committee determination or by hearing and appellate review:

   a. The Practitioner may upon completion of a time limited period ask the Executive Committee via the Credentials Committee for resumption of medical staff membership and/or reinstatement privileges.

   b. The Credentials Committee shall verify the report of the Practitioner and communicate with monitors and mandated consultants and/or supervisors prior to making written recommendation to the Executive Committee.

   c. The Executive Committee shall review the information with the Chair of the Credentials Committee in Closed Session and make further recommendations to the Board on what status and privileges to resume, to continue monitoring, or to deny.

   d. If the practitioner elects to submit a request to overturn a decision perceived to be adverse by the practitioner to the Board, then the request must be in writing, must reference the specific restrictions for which the request is made, must include documentation from the monitors, mandatory consultants, and/or supervisors that reports the rectification of the problems in question

Section J. Re-application for Medical Staff Membership for Individuals Terminated Due to Corrective Action.

Once an individual's membership on the Medical Staff has been terminated for cause, as outlined in the Corrective Action section of these Bylaws, the Practitioner may not reapply for readmission to Medical Staff Membership for five (5) years.

ARTICLE XVIII. HEARING AND APPELLATE REVIEW

NOTE: Any appearance of conflict of interest will be resolved by the Medical Staff leadership.

Section A. Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under Article XVII.

1. "Body whose decision prompted the hearing" refers to the committee or body, which, pursuant to the Medical Staff Bylaws, rendered the decision, which resulted in the request for the hearing.

2. "Notice" shall be a written communication sent by certified or registered mail, return-receipt-requested, to the last address of the practitioner on file with the Hospital.

3. "Persons who requested the hearing" refers to the applicant, practitioner or Medical Staff member who requested hearing pursuant to these Bylaws.

4. "Professional Review Committee" shall be that body appointed by the Chief of the Medical Staff to conduct a hearing duly requested by a practitioner.

5. "Suspension" means to bar temporarily from a privilege or Medical Staff membership.

6. "Memorandum of points and authorities" refers to a document or documents used in a hearing which outline (s) key points of concern, used to present or rebut allegations, and refers to, paraphrases, and/or quotes pertinent publications.

7. "Corrective Action Advisory Panel" shall be that body appointed by the Chief of Staff to represent the Executive Committee and oversee the Corrective Action process.

Section B. Hearing Request and Set-up

A request for a hearing shall be made in writing to the CEO of the Hospital within 30 days of notice of an adverse action or the right to a hearing is forfeited.

1. Grounds for Hearing: Any one or more of the following actions may constitute grounds for a hearing:

   a. Denial of Medical Staff application

   b. Denial of Medical Staff reappointment.

   c. Suspension of Medical Staff membership if it adversely impacts clinical privileges.

   d. Revocation of Medical Staff membership (except as pursuant to these Bylaws pertaining to automatic or administrative suspension or license revocation provisions).

   e. Reduction in privileges.

   f. Suspension of privileges (except as pursuant to these Bylaws)

   g. Termination of privileges.

2. Conduct of Hearing and Notice

a. Mandatory Notice: Prior to implementation of Corrective Action against a Practitioner, the Practitioner must be given written notice by the Chief Executive Officer (except as noted in Summary Suspension of these Bylaws) stating the following:

i. that a professional review action has been proposed and the reasons for that proposed action; and

ii. that the Practitioner has the right to request a hearing on the proposed action, said notice must set forth a specific response time of not less than thirty (30) calendar days of notice within which to make written request to the CEO and Chief of the Medical Staff for a hearing; and

iii. A summary of the Practitioner's rights at the hearing as set forth in these Bylaws.

iv. This notice shall be transmitted by the Chief Executive Officer, either by hand delivery or by certified mail. (If the practitioner refuses to sign for the letter or seems unable to be located a second attempt to deliver the letter by courier or certified mail addressed to the practitioner's last known address may be signed by the courier indicating the date of attempted delivery. The signature of the courier will serve as adequate effort to serve notice to the practitioner).: The following will be informed of this notice:

a. The Chief of the Medical Staff

b. The Chief of the Department involved

c. The Chairman of the Credentials Committee; and

d. The Chairman of the Board of the Florida Health Sciences Center

b. Failure to Properly Request a Hearing

i. In the event the member or applicant does not request a hearing within the time and manner herein above set forth, the practitioner shall be deemed to have waived his right to a Hearing and/or Appellate Review.

ii. Notice shall be given to the Executive Committee by the Chief of the Medical Staff and the Board of this matter and the Board shall make a final and binding decision.

a. The Board shall decide either to affirm or modify the adverse recommendations forwarded by the Executive Committee, which shall become the final determination.

b. The final determination shall be communicated to the Practitioner within fifteen (15) calendar days of said notice.

c. The Practitioner may file a request for reconsideration with the Board, which can only be based upon grounds listed in this section below:

d. Such an appeal shall be directly to the Board.

e. The Board shall then follow the provisions of Section E, 3, 4, 5, 6, and 7.

3. Time and Place of Hearing

a. Upon receipt of a request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of the Medical Staff who shall appoint a Corrective Action Advisory Panel as set forth in Section B.4. and a Professional Review Committee as in Section B 5.

b. The Chief of the Medical Staff (or acting Chief of the Medical Staff) shall have twenty-one (21) calendar days from the date of the request for a hearing in which to appoint a Professional Review Committee and a Chair as set forth in Section B 5.

c. The Chief of the Medical Staff (or acting Chief of the Medical Staff) shall deliver the request for a hearing to the Chair of the Professional Review Committee.

d. The Chair of the Professional Review Committee shall have twenty-one (21) calendar days from the date of his or her appointment to schedule a hearing date and give written notice to the person who requested the hearing, which notice shall include the place, time, and date of the hearing.

e. The date of the hearing shall not be less than thirty (30) calendar days nor more than forty-five (45) days from the notification of time and date of the hearing.

4. Notice of Charges and Hearing.

a. The Executive Committee or the Chief of the Medical Staff shall appoint a Corrective Action Advisory Panel whose function is to oversee the Corrective Action process and act as the representative of the Medical Staff. The Chief of Staff or designee shall act as the Chair of the Corrective Action Advisory Panel which shall include at least two other members of the Executive Committee. One of the members of the Corrective Action Advisory Panel shall be appointed to represent the Executive Committee at the hearing and who will in consultation with legal counsel:

i. Review witness statements and results of medical record reviews, and prepare a list of charges and allegations.

ii. Draft a Notice of Charges, within fifteen (15) calendar days after having received the request for a hearing, which shall include:

a. a concise statement of the Practitioner's alleged acts, omissions, or deficiencies,

b. a list by number of specific, or representative, patient medical records in question detailed by initials and Medical Record number.

c. other reasons or subject matter, if any, forming the basis for the adverse action or recommendation which constitutes the subject of the hearing,

d. a list of potential witnesses, if any, expected to testify at the hearing,

e. a list of all appointed members of the Professional Review Committee,

f. the name of the medical staff representative who will present the concerns that prompted the adverse action.

iii. The Corrective Action Advisory Panel shall forward the Notice of Charges to the Professional Review Committee Chair as soon as possible.

a. The Chair of the Professional Review Committee shall schedule a hearing date as set forth in Section B 3.

b. The Chair of the Professional Review Committee shall provide notice to Practitioner. The notice shall be in writing and shall include:

i. the Notice of Charges, and

ii. the place, time, and date of the hearing.

b. The Corrective Action Advisory Panel shall be kept informed of the proceedings, including communications from the Practitioner undergoing Corrective Action and any recommendations of legal counsel.

c. The Corrective Action Advisory Panel shall review and approve the draft Notice of Charges.

5. Professional Review Committee

a. The Professional Review Committee:

i. shall have a chair appointed by the Chief of the Medical Staff.

ii. shall consist of five (5) members of the Active Medical Staff and should include past officers of the Medical Staff when possible, but no person who has a potential conflict of interest shall be appointed to the Professional Review Committee. In addition to the five (5) members of the Professional Review Committee, the Chief of the Medical Staff shall appoint one (1) alternate. The alternate will not participate unless required to replace a

Committee member who is no longer able to fulfill their duties. All members of the Professional Review Committee (including any alternate who participated in the hearing process) shall sign a Conflict-of-Interest Disclosure Statement at the time the written decision of the Professional Review Committee is prepared. (Conflict-of-Interest Disclosure Statement: I herewith notify the Medical Executive Committee that I have no perceived conflict of interest and that the following information may be construed by reasonable persons to represent a conflict of interest: being a former partner, associate of the accused, considering or having current or past litigation against the accused, being in direct economic competition with the accused, being involved in the accusation of, investigation of, or in the deliberation on the current issue, or any other relationship with the accused that might be perceived as a potential conflict).

iii. A quorum shall consist of a majority of the members and a decision shall be by a majority of the members present.

iv. Any member of the Professional Review Committee (including any alternate) who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the member is not in personal attendance shall be permitted to participate in deliberations and to vote on the recommendations of the Professional Review Committee.

b. A Medical Staff member is not disqualified from service on the Professional Review Committee merely because he has heard of the case or has knowledge of the allegations

c. In the event that a member of the Professional Review Committee resigns, the alternate shall assume that member's place on the Committee. In the event that more than one member of the Professional Review Committee resigns, the Chief of the Medical Staff shall appoint additional replacement members as needed to maintain a Professional Review Committee consisting of five (5) members.

d. The Practitioner may challenge whether any appointed member of the Professional Review Committee has a potential conflict of interest.

i. Any such challenge must occur at least fifteen (15) calendar days prior to the Hearing date.

ii. The challenge shall be reviewed by the Credentials Committee at their regular session or in special session. The decision of the Credentials Committee is considered final.

iii. In the event that a Professional Review Committee member is determined to have a conflict of interest by the Credentials Committee, the alternate shall replace the member with the conflict of interest and the Chief of the Medical Staff shall appoint another alternate.

6. Disclosure of evidence and witnesses

a. By Medical Staff.

At least thirty (30) calendar days prior to the hearing the Chair of the Professional Review Committee shall provide the Practitioner with the Notice of Charges

b. By Practitioner.

At least ten (10) calendar days prior to the hearing the Practitioner shall provide the Medical Staff with the following:

i. a statement setting forth the reasons why the Practitioner contends that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis,

ii. a list of witnesses the Practitioner will call to testify and a summary of the subject matter of the witnesses testimony, and

iii. a copy of all documents the Practitioner intends to introduce at the hearing.

c. Neither the Medical Staff nor the Practitioner may call any witness, nor elicit any testimony or opinions from any witness, nor present any documents for consideration by the Professional Review Committee, which have not been disclosed in accordance with this Section, unless the Professional Review Committee determines that any failure to disclose was unavoidable.

7. Notice of Representation.

a. By Practitioner.

If the Practitioner elects representation, the Practitioner must identify the representative by name in writing to the Chair of the Professional Review Committee no less than ten (10) calendar days prior to the Hearing.

b. By Medical Staff.

If the Practitioner provides notice of representation, the Medical Staff shall provide Practitioner with the name and contact information of its legal counsel

Section C. Hearing Procedure

1. Personal Presence Mandatory:

a. The hearing will not be conducted without the personal presence of the person requesting the hearing unless the Practitioner has waived such appearance or has failed to appear after appropriate notice.

b. Failure to appear without good cause of the person requesting the Hearing shall be deemed to constitute voluntary acceptance of the action, which shall become final and effective immediately.

c. Postponement of the Professional Review Committee Hearing may be granted by the Professional Review Committee Chair only upon showing good cause

2. Representation

a. Upon timely prior notice, the Practitioner has the right to be represented by an attorney-at-law or other Practitioner of Practitioner's choice, however, only one such representative may accompany the Practitioner to the hearing and that representative may not respond for the Practitioner to questions personally directed to the Practitioner. If the Practitioner fails to notify the Chair at least ten (10) calendar days prior to the hearing, at the Chair's discretion, the following may occur:

i. the representative may not be allowed to attend,

ii. the Hearing may proceed with the Practitioner's representative, or

iii. the hearing may be postponed for sufficient time for the Chief of the Medical Staff and the CEO to decide whether to select and review the case with an attorney-at-law to represent the Hospital.

b. Pursuant to Article XVII, Section B.4, The Executive Committee or the Chief of the Medical Staff shall appoint an appropriate member of the Executive Committee who will at the hearing present the concerns that prompted the adverse action. The Medical Staff may at its discretion, use either; an attorney, or said representative, to call and examine witnesses in support of the adverse action and to examine the Practitioner's witnesses.

3. The Hearing Officer: The hearing officer at the hearing shall:

a. be an attorney or other individual familiar with procedures relating to peer review hearings,

b. act to ensure:

i. that all participants in the hearing have a reasonable opportunity to be heard,

ii. that all participants have an opportunity to present all oral and documentary information, and

iii. that decorum is maintained by whatever reasonable means necessary, including the dismissal of any who persist with disorderly conduct.

iv. that all witnesses be excluded from the hearing until called upon to testify.

v. that the proceedings shall not be videotaped

c. determine the order of procedure during the hearing,

d. have the authority and discretion, in accordance with these Bylaws, to:

i. to make all rulings on questions, which pertain to matters of procedure and to the admissibility of relevant information.

ii. to recess and reconvene the hearing

iii. to impose reasonable time limits for examinations and cross-examinations of witnesses

iv. to limit the number of witnesses to be called by either party.

v. set reasonable time limits for the completion of the hearing process, including the authority to select deadlines whereby the hearing process shall be completed.

vi. to extend the deadline for completion of the hearing process upon a showing of good cause.

e. rule on any objections to testimony or evidence as set forth in Section C 6.

f. be available to the members of the Professional Review Committee throughout the process of the hearing to advise them on any procedural or legal matters, and at the Committee's discretion may assist the Committee with the drafting of their report and recommendations, but shall not take part in any deliberation or vote.

4. Record of Hearing

a. The Professional Review Committee must maintain a record of the hearing by one of the following methods:

i. a stenographer (court) reporter present to make and transcribe the hearing; or

ii. an audio recording of the hearing.

b. The affected Practitioner shall be provided a written transcript of the hearing at the time that the written decision is distributed. The transcript shall be made available at no charge to the Practitioner.

5. Rights of Both Sides

At the hearing, both sides shall have the following rights:

a. to call and question witnesses,

b. to introduce exhibits,

c. to question any witness on any matter relevant to the issues and to rebut any information or testimony, and

d. to present a written closing argument which may include a memorandum on points and authorities. No oral closing arguments will be permitted.

6. Admissibility of Relevant Information

a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of information.

b. Any relevant information and material shall be admitted by the Hearing Officer if it is the sort of information and material on which responsible physicians are accustomed to rely upon in the conduct of serious affairs.

c. All portions of any TGH medical record shall be considered the sort of information and material on which responsible persons are accustomed to rely upon.

d. The notice of charges, all communications between the Practitioner and TGH and/or its Medical Staff, and any letter or notice of summary suspension shall be admitted at the onset of the proceedings and available for review by the Professional Review Committee members.

e. Each party shall have the right to submit a memorandum of points and authorities, and the Professional Review Committee may request that any such a memorandum used at the hearing be filed at the close of the hearing. Any such document shall be attached to the transcript and final written decision of the Professional Review Committee.

f. The Professional Review Committee may question the witnesses, call additional witnesses, or request, receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice and provided adequate opportunity to challenge or rebut such evidence. The hearing officer may recess the hearing as he or she deems appropriate to obtain further information or evidence.

g. Except as specifically provided in this fair hearing plan, there shall be no right to conduct formal discovery in connection with any hearing. No Practitioner shall be permitted access to or to introduce any evidence of any peer review records, minutes or other documents or information relating to any other practitioner, or any actions taken or not taken with regard to any other practitioner. The Practitioner requesting a hearing shall, however, be entitled to any documents relied on by the Medical Executive Committee or Board in making any recommendation or decision, any documents to be introduced at the hearing, so long as the individual and his or her counsel agree in writing to keep all such documents and their contents confidential and agrees that any such documents may be used only in connection with this hearing. The production of such documents shall not constitute a waiver of any peer review protection for those or any other documents.

h. It shall not a be a defense to any action that different action may have been taken in the past with regard to any other staff member and no such information shall be admissible.

7. Official Notice

a. The Hearing Officer shall have the discretion, after consultation with the Chair of the Professional Review Committee, to take official notice of any matter either technical or scientific, relating to the issues under consideration.

b. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of the hearing.

c. The person requesting the hearing shall have the opportunity to request that a matter be officially noticed or to refute the official noticed matters by information and material or by written or oral presentation.

d. Reasonable or additional time may be granted if requested, to present written rebuttal of any information and material admitted on official notice. The Hearing Officer shall have discretion to determine if the information or material submitted is sufficiently pertinent to continue the Hearing to another date or time in order to allow preparation of such rebuttal.

8. Basis of Decision shall be derived from material produced at the hearing. Said information and material may consist of the following:

a. oral testimony of witnesses,

b. written closing arguments, briefs, or memorandum of points and authorities presented in connection with the hearing,

c. any relevant material contained in the Medical Staff's personal files regarding the person who requested the hearing,

d. any relevant material about the person who made a written complaint about the Practitioner,

e. any and all applications, references, and accompanying documents; and

f. all officially noticed matters (e.g., published legal notices, published Florida Board of Medicine reports, and other credible published or written documents).

9. Burden of Proof

a. he Practitioner has the burden of proving by a preponderance of convincing information and material that the adverse action or recommendation lacks substantial factual basis or that the conclusions drawn from are arbitrary, unreasonable or capricious.

b. Otherwise, the body whose adverse action or recommendation occasioned the hearing has the initial obligation to present information and material in support thereof; but the practitioner has the responsibility for supporting, by a preponderance of the information and material, the challenge that the adverse action or recommendation lacks substantial factual basis or that the basis of the conclusions drawn from are either arbitrary, unreasonable or capricious.

10. Adjournment

The Hearing 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 information, the hearing shall be closed. The Professional Review Committee shall thereupon, outside the presence of any other

person, conduct its deliberations and render a written decision with an accompanying report as provided below in Section D below.

Section D. Decision of the Professional Review Committee

1. Decision

a. Within thirty (30) calendar days following the completion of the hearing, the Professional Review Committee shall render a written decision.

b. The Written Decision shall include:

i. the adverse action,

ii. the reasons for the adverse action,

iii. the names of the Professional Review Committee members, the Medical Staff Representative, and the names of the individuals present qualifying a quorum (Professional Review Committee members not in attendance should be listed as not present),

iv. the recommendation of the Professional Review Committee, including a statement of the basis for the recommendation, and

v. the signature of at least three (3) members of the Professional Review Committee including the Chair.

c. All members of the Professional Review Committee shall sign a Conflict of Interest Disclosure Statement at the time the Written Decision of the Professional Review Committee is prepared.

d. The written decision shall be delivered to the Chief of the Medical Staff.

2. Within fifteen (15) calendar days of the issuance of the written decision, the Chief of the Medical Staff shall distribute the written decision to the following:

a. the Executive Committee

b. the Board via the Chief Executive Officer,

c. the Practitioner in question, via Registered or Certified Mail, return-receipt-requested, indicating date of delivery.

3. The Written Decision of the Professional Review Committee shall conclude the Committee's responsibility.

4. Processing of the Decision of the Professional Review Committee

a. Executive Committee Processing of Decision.

i. At or before its next scheduled meeting the Executive Committee, shall review the written decision of the Professional Review Committee. If the Executive Committee finds that there was not a substantial conflict of interest and that the conduct of the Professional Review Committee met the requirements under the

Bylaws, the Executive Committee shall vote to accept or pass on without written comment the written decision.

ii. If the written decision is accepted by the Executive Committee by majority vote, or passed on without written comment, the written decision shall be forwarded via the Chief Executive Officer to the Board for presentation at its next scheduled meeting.

iii. If the Executive Committee finds that a substantial conflict of interest exists or that the conduct of the Professional Review Committee did not meet Bylaws policy, the Executive Committee may decide

a. whether to forward the written decision to the Board with written comment in reference to the issues and concerns; or

b. vacate the written decision and set a new hearing and new Professional Review Committee.

iv. In the event that the Executive Committee elects to appoint a new Professional Review Committee, the Practitioner, the person or body that prompted the adverse action, the Chief Executive Officer, and the Board are to be notified in writing within 7 calendar days. The new Professional Review Committee shall be appointed by the Chief of the Medical Staff according to Section B.5.a of this Article and such appointment shall restart the hearing process anew.

b. Board's Processing of a Decision forwarded by the Executive Committee.

i. After the time limit for an appeal has passed, as stated in this Article, Section E.1, the Board shall review the written decision of the Professional Review Committee, and any written comments from the Executive Committee. The Board shall then issue a decision in writing. The Board may affirm, modify or reverse the decision of the Professional Review Committee or at its discretion may refer the matter for further review and recommendation by the Professional Review Committee.

ii. Within fifteen (15) calendar days, after the date the Board issues its decision, the Chief Executive Officer shall deliver copies thereof in person or by certified or registered mail to:

a. The practitioner for whom the hearing was called, and

b. The Chief of the Medical Staff.

Section E. Appeal to the Board

1. Time Limit for Appeal

Within fifteen (15) days after receipt of the decision of the Professional Review Committee, either the person who requested the hearing or the body whose

decision prompted the hearing may request an appellate review by the Board. Said request shall:

a. be delivered to the Chief Executive Officer in writing,

b. be delivered either in person or by certified or registered mail; and

c. be in writing and shall include a brief statement of the reason for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become final and shall be effective immediately.

2. Grounds for Appeal

The grounds for appeal shall be substantial failure of the Professional Review Committee, or Executive Committee to comply with the procedures required by these Bylaws.

3. Time, Place and Notice

In the event of an appeal to the Board as set forth in the preceding subsection, the Board shall arrange for an appellate review. The Board shall:

a. Within fifteen (15) days after receipt of such notice of appeal, schedule and arrange for an appellate review, and

b. cause the applicant or members to be given notice of the time, place and date of the appellate review which shall be not less than fifteen (15) days nor more than ninety (90) days from the date of receipt of the request for the appellate review. The time for the appellate review may be extended by the Chairman of the Board if requested by practitioner.

4. Nature of Appellate Review

a. Board Proceedings

The proceedings of the Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Professional Review Committee, providing that the Board may, at its sole discretion, accept additional information subject to the same rights to question or confront witnesses provided at the Professional Review Committee hearing.

i. The Executive Committee shall send two representatives to the Board for the Appellate Review.

a. the Chair of the Professional Review Committee; and

b. the appointed Executive Committee representative who prepared the allegations and issues for the hearing.

ii. The purpose of the two representatives is as follows:

a. present the pertinent Bylaws information that applies to the hearing and appellate review process,

b. present the case, issues, and allegations, for which an adverse action was recommended against the Practitioner,

c. provide information on how the hearing procedures were managed; and

d. answer questions about or offer rebuttals of information presented by the Practitioner or the Practitioner's representative.

b. Board May Allow Personal Appearance

In its sole discretion the Board may allow both the designated representative and the affected practitioner to personally appear and make oral arguments.

c. Deliberations Outside Presence of Appellant

At the conclusion of the oral argument, if allowed, the Board may at a time convenient to itself conduct deliberations outside the presence of the appellant or his representative.

d. Board's Decision

The Board may affirm, modify or reverse the decision of the Professional Review Committee or at its discretion may refer the matter for further review and recommendation by the Professional Review Committee.

e. Legal Counsel

The practitioner requesting the hearing, the Executive Committee, and the Board may be represented in any phase of the appeals procedure by an attorney at law.

5. Further Review

a. Except where the matter is referred for further review and recommendation in accordance with this Article, Section E.4.d. or Section E.5.c, the final decision of the Board, shall be effective immediately upon receipt of the written report of the Board as delivered to the CEO.

b. If the matter is referred back to the Professional Review Committee for further review and recommendations, their report shall be managed as in Section D, Decision of the Professional Review Committee. Within sixty (60) days of the written report of the Board, the further review written report of the Professional Review Committee shall be delivered through the Executive Committee back to the Board.

c. In the event that the Board finds substantial evidence that the process and/or outcome of the hearing needs to be addressed anew, the Board may refer the matter back to the Chief of the Medical Staff to appoint a wholly new Professional Review Committee. The Chief of Staff shall do so within 10 business days and shall, by review of the written report of the

Board, so notify the Executive Committee at its next closed session. Such referral will start the hearing and appellate review process anew.

6. Final Decision

Within sixty (60) days after the conclusion of the proceedings before the Board, the Board shall render a final decision in writing through the Chief Executive Officer and the Chief Executive Officer shall deliver copies thereof in person or by certified or registered mail to:

a. The practitioner for whom the hearing was called, and

b. The Chief of the Medical Staff.

7. Right to One Hearing and One Appeal Only

Except as otherwise provided in these Bylaws, no Practitioner shall be subject to or entitled to more than one hearing before the Board on a single specific matter which may be the subject of appeal. No Practitioner is entitled to more than one appeal before the Board

Section F. Immunity

All staff members participating in the request for a Corrective Action, the actions of the Investigative Committee, the actions of the Executive Committee, and the actions of the appellate committee as provided for in these Bylaws shall be deemed members of a medical review committee as defined in Section 766.101 of the Florida Statute and entitled to all the protection from liability provided for in such statute or any similar statutes which provide that there shall be no monetary liability on the part of and no cause of action for damages against any member of such committee so long as no intentional fraud is committed by such person.

EXHIBIT 1

To: _____ Date: _____

This letter is to notify you that a Committee has been formed to investigate certain allegations against you. This action has been taken in accordance with the authority granted in Article XVI, Section A. of the Medical Staff Bylaws.

Attention: If you terminate your clinical privileges while under this investigation, for any reason, Tampa General Hospital is required to report your actions to the National Practitioner Data Bank.

In general, this investigation was initiated based on the following:

You are invited to discuss, explain, and/or refute the matters under investigation.

Pursuant to the Medical Staff Bylaws, at the conclusion of its investigation, this Committee shall prepare a written response recommending any further action. The written response shall include a summary of the interviews conducted with you and any others with knowledge of relevant events, and a summary of any pertinent information. This written response will be reviewed by the Executive Committee at its next meeting, in closed session.

Following review by the Executive Committee, you shall be notified of the final decision.

I hereby disclose that I am not aware of any potential conflicts of interest or litigation that may be construed as biasing me in this matter.

Sincerely,

_____
Chair of the Investigative Committee

cc: Chief of Staff
CEO,
Chief of Department

EXHIBIT 2

NOTICE OF SUMMARY SUSPENSION

This letter is to notify you that your clinical privileges as a member of the Medical Staff at Tampa General Hospital are summarily suspended, effective immediately. This action has been taken in accordance with my authority pursuant to Article XVI, Section B. of the Medical Staff Bylaws.

This summary suspension is, in my judgment, necessary to:

☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient.
☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any employee.
☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any person present in the hospital
☐ protect the life of any patient.

Pursuant to the Medical Staff Bylaws, this summary action will be reviewed by the Executive Committee at its next meeting, in closed session. The Executive Committee may modify, continue, or terminate the summary action upon its review.

Pursuant to the Medical Staff Bylaws, you have the right to request a hearing by a Professional Review Committee. Any such request must reference this letter, must be in writing, and must be delivered to the Chief of Staff, or to the Chief Executive Officer of Tampa General Hospital. Your request must be received within thirty (30) calendar days of the date of this letter. If no request for a hearing is received within thirty (30) days, the summary action will become final on the thirty first (31st) day, and may not be appealed.

At least ten (10) calendar days prior to the hearing you must provide the Medical Staff with the following information in writing:

- a statement setting forth the reasons why you contend that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis,
- a list of witnesses you will call to testify and a summary of the subject matter of the witnesses testimony,
- a copy of all documents you intend to introduce at the hearing; and
- if you elect to be represented, you must provide the name of that representative

At the hearing, you will have the following rights pursuant to the Medical Staff Bylaws:

- to personally be present at the hearing,
- to be represented by an attorney-at-law or other Practitioner of your choice as previously disclosed,
- to call and question those witnesses previously disclosed,
- to introduce exhibits previously disclosed,
- to question any witness on any matter relevant to the issues and to rebut any information or testimony, and
- to submit a written closing argument which may include a memorandum of points and authorities.

The following are the activities or conduct responsible for this summary suspension:
(Include patient medical record numbers and as much detail as available.)

_____

I hereby disclose that I am not aware of any potential conflicts of interest or litigation that may be construed as biasing me in this matter.

Sincerely,

_____

cc: Chief of Staff
CEO
Chief of Department
(Chair of the Credentials Committee)
(Chair of the FHSC Board of Directors)

EXHIBIT 3

NOTICE OF SUMMARY ACTION

To: _____ Date: _____

☐ Mandatory second opinion prior to performing a procedure
☐ Mandatory supervision
☐ Mandatory consultation
☐ Other - describe restriction(s)

This action has been taken in accordance with my authority pursuant to Section B of Article XVI in the Medical Staff Bylaws and shall remain in effective until _____ unless otherwise ordered by the Executive Committee. (not to exceed one year)

This summary action is, in my judgment, necessary to:

☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient.
☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any employee.
☐ reduce the substantial likelihood of immediate injury or damage to the health or safety of any person present in the hospital
☐ protect the life of any patient.

Pursuant to the Medical Staff Bylaws, this summary action will be reviewed by the Executive Committee at its next meeting, in closed session. The Executive Committee may modify, continue, or terminate the summary action upon its review.

Pursuant to the Medical Staff Bylaws, you have the right to request a hearing by a Professional Review Committee. Any such request must reference this letter, must be in writing, and must be delivered to the Chief of Staff, or to the Chief Executive Officer of the Tampa General Hospital. Your request must be received within thirty (30) calendar days of the date of this letter. If no request for a hearing is received within thirty (30) days, the summary action will become final on the thirty first (31st) day, and may not be appealed.

At least ten (10) calendar days prior to the hearing you must provide the Medical Staff with the following information in writing:

1. a statement setting forth the reasons why you contend that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis,
2. a list of witnesses you will call to testify and a summary of the subject matter of the witnesses testimony,
3. a copy of all documents you intend to introduce at the hearing; and
4. if you elect to be represented, you must provide the name of that representative
5. At the hearing, you will have the following rights pursuant to the Medical Staff Bylaws:
6. to personally be present at the hearing,

7. to be represented by an attorney-at-law or other Practitioner of your choice as previously disclosed,
8. to call and question those witnesses previously disclosed,
9. to introduce exhibits previously disclosed,
10. to question any witness on any matter relevant to the issues and to rebut any information or testimony, and
11. to submit a written closing argument which may include a memorandum of points and authorities.

The following are the activities or conduct responsible for this summary action:
(Include patient identifiers and details of the incident(s). Attach a separate sheet as needed)

_____

I hereby disclose that I am not aware of any potential conflicts of interest or litigation that may be construed as biasing me in this matter.

Sincerely,

_____

cc: Chief of Staff
CEO
Chief of Department
(Chair, Credentials Committee)
(Chair of the FHSC Board of Directors)

ATTACHMENT A

Officer responsibilities may include, but are not limited to those identified below.

Chief of Staff Specific Responsibilities

1. Chairs Medical Executive Committee and Medical Staff Officers meetings
2. Represents the Medical Staff at the FHSC Board meetings
3. Represents the Medical Staff at Senior Management Meetings (shares responsibility with Past Chief of Staff)
4. Represents the Medical Staff on the Risk Management Committee (all Code 15 & Sentinel Events are communicated to the COS prior to any reporting)
5. Participates in Credentials Committee meetings
6. Enforces Disruptive Physician Policy with the Medical Staff
7. Supervises Corrective Action process
8. Works with Chiefs of Department/Sections to address appropriate issues pertinent to their areas
9. Oversees the planning of the Annual Meeting with Medical Staff Services
10. Responds to Medical Staff complaints, concerns, and input, and then addressing and/or submitting to appropriate forum or committee
11. Attends or makes arrangements for another Medical Staff Officer to attend all appropriate hospital or community functions where medical staff representation is desired or requested
12. Works closely and communicates effectively with other Medical Staff Officers to ensure all functions of the Medical Staff are accomplished
13. Works with the CEO and other Senior Management, especially the CNO & CMO individually and collectively and participates in meetings as necessary
14. Leads physician Community Relations within hospital (e.g. White Coat program and tours)
15. Represents the Medical Staff as a Media contact
16. Works closely with Medical Staff Services (MSS)--includes meeting regularly with the Director, acting as resource for issues, signing checks when needed, reviewing credentials of appointments/reappointments as necessary
17. Oversees the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process
18. Ensures the transition of the Vice Chief to the Chief responsibilities

Vice Chief of Staff Specific Responsibilities

1 Chairs Professionalism Committee meetings
2. Participates in Medical Staff Officers and Medical Executive Committee meetings
3. Participates in Bylaws Committee meetings
4. Serves as Executive Committee representative and ensures process follows the Bylaws in Correction Action Process
5. Works with other Officers of the Medical Staff to ensure all functions of the Medical Staff are accomplished
6. Works with Medical Staff Services (MSS)—acting as resource for issues, signing checks when needed, reviewing credentials of appointment/reappointments as necessary
7. Attends FHSC Board meetings when invited by Chief of Staff or the FHSC Board.

Secretary/Treasurer Specific Responsibilities

1. Works closely with all Performance Improvement Teams
2. Participates in Medical Staff Officers and Medical Executive Committee meetings
3. Participates in Hospital Quality Committee meetings and oversees Medical Staff Quality Improvement
4. Organizes and ensures that the Peer Review Process is done in a fair and effective way

5. Presents quality, committee, and department/section reports at Executive Committee meetings
6. Works with other Officers of the Medical Staff to ensure all functions of the Medical Staff are accomplished
7. Works with Medical Staff Services (MSS)—acting as resource for issues, preparing and signing checks when needed, reviewing credentials of appointment/reappointments as necessary

Past Chief of Staff Specific Responsibilities

1. Participates in Senior Management meetings when necessary
2. Participates in Medical Staff Officers meetings
3. Serves as resource to the other Officers
4. Represents the Medical Staff to the HCHA and functions as Liaison
5. Chairs Peer Review Committee meetings
6. Represents the Medical Staff on the TGH Foundation Board
7. Represents the Medical Staff as a Media contact
8. Participates with physician Community Relations within hospital (e.g. White Coat program and tours)
9. Works with Medical staff Services (MSS)—acting as resource for issues

APPENDIX A –
ADVANCED PRACTICE PROVIDERS PHYSICIAN FIRST ASSISTANTS, AND NON-PHYSICIAN FIRST ASSISTANTS

Qualified Advanced Practice Providers (APPs) Physician First Assistants (PFAs), and Non-Physician First Assistants, may be granted clinical privileges, but are not eligible for membership on the Medical Staff. A formal written request/recommendation must be submitted by an Active Surgical Medical Staff Member in good standing.

Advanced Practice Providers, Physician First Assistants, and Non-Physician First Assistants, shall be subject to the TGH Medical Staff Bylaws, Medical Staff Rules and Regulations, and any and all hospital policies and procedures in accordance with the Medical Staff Bylaws.

An Advanced Practice Provider (APP) is an individual other than a physician, oral surgeon, dentist, podiatrist, or psychologist who is qualified by academic clinical training or other training and by prior and continuing experience and current competence in a discipline which the Board has determined is allowed to practice in the Hospital and who is licensed by the State of Florida to perform patient care services ordinarily performed by a physician under the direction of the physician and with mutually agreed upon guidelines.

A Physician First Assistant is a physician licensed in the State of Florida under Chapters 458 or 459 whose clinical privileges are limited to those of a physician surgical assistant.

A Non-Physician First Assistant is a person licensed or certified in the State of Florida whose clinical privileges are limited to those of a surgical assistant

Section A. Current Categories of Advanced Practice Providers

The Board permits the following categories of APPs to provide patient care services at Tampa General Hospital:

- Advanced Practice Registered Nurse (APRN))
  - Certified Registered Nurse Anesthetists (CRNA)Certified Nurse Midwives (CNM)
  - Clinical Nurse Specialist (CNS)
- Physician Assistant - Certified (PA)

1. General

   APPs are those individuals licensed in the State of Florida, who, under applicable state law, are either not permitted to provide independent clinical services without direct physician supervision and/or per collaborative agreement, or who at the discretion of the Board of the Florida Health Sciences Center, are members of categories of practitioners approved by the Board to provide patient care services within the Hospital under the direction and supervision of the Medical Staff member or group of such members. Written guidelines defining the specified services that may be provided by each category of dependent APP and level of supervision shall be established in accordance with applicable state and federal laws and Rules and Regulations in conjunction with the APP and designated physician supervisor (licensed under Chapters 458, 459, or 464, subject to input from the respective Department/Section Chief and review and approval by the Credentials Committee and Medical Executive Committee. These professionals must have designated physician supervision with demonstrated liability coverage with limits no less than required by the Board.

2. Scope of Practice (except Certified Nurse Midwives)

May provide patient care services within the limits of their education, training and professional skills and abilities. Degree of participation shall be determined according to protocol or delineation of patient care services reviewed and signed by the Chief of the Section/Department, reviewed and approved by the Credentials Committee, Medical Executive Committee, the Board, and in accordance with Florida Statutes and/or Administrative Rules/Regulations (Physician Assistants - Chapter 458.347-348 and 459.022; Advanced Registered Nurse Practitioners including Certified Registered Nurse Anesthetists - Chapter 464 and Chapter 64B9 F.A.C.

Note: Granting of any of the patient care services requested by the applicant does not exempt the supervising physician from total responsibility of the care of the patient, including timely completion and authentication of all medical record documentation.

a. Application for clinical privileges, review of performance, and voluntary/involuntary revocation or reduction of patient care services shall follow the same procedures as outlined in Article XV of these Bylaws.

b. Hospital clinical privileges shall automatically terminate upon termination of staff membership of the advance practice professional's supervising physician or termination of the relationship between the APP and specified supervising physician(s). The APP may resume providing patient care services as previously privileged when another member of the Medical Staff has accepted the responsibility for supervision in writing and a new or revised collaborative protocol with the same previously approved clinical privileges has been signed by the APP and the new supervising physician, and been submitted to the medical staff office. Review and approval by the Advanced Practice Provider Credentialing and Authorization Committee, the Credentials Committee, Medical Executive Committee and Board will be required if there are any changes other than the supervising physician.

c. Advanced Practice Providers in this category shall have no admitting privileges and may attend patients in the Hospital only if requested by a member of the Medical Staff. The attending physician must be responsible for the history and physical examination and the overall medical care of the patient.

d. The Executive Committee will assign each advance practice professional to the appropriate Department and Section, where the APP may attend meetings without vote. Each APP may serve with or without vote on appropriate Medical Staff committees, as appointed by the Chief of Staff. Monitoring of quality of care provided by advance practice provider and delineation of patient care services shall be the responsibility of the Department or Section to which the practitioner is assigned. APPs may also be invited to attend Medical Staff meetings, and as a condition of continued clinical privileges be required to attend meetings that involve the clinical review of patient care in which they participated.

3. Scope of Practice (Certified Nurse Midwives):

a. May provide patient care services within the scope of their education, training, experience and the limits of their professional skills and abilities in accordance with Chapters 464 esp. 464.012, and according to collaborative agreement filed and maintained under the provisions of Chapter 64B9-4.010 and the delineation of clinical privileges reviewed and signed by the Chief of the Department of Obstetrics and Gynecology, reviewed and approved by the Credentials Committee, the Medical Executive Committee and the Board, and in accordance with the cited Florida Statutes and the Rules and Regulations.

b. May participate directly in patient management and care under the general supervision or direction of a Medical Staff appointee in the Department of Obstetrics and Gynecology.

c. May record reports and progress notes on patient records and write treatment orders to the extent established in the Medical Staff Rules and Regulations provided that such orders are within the scope of his or her license or certificate;

d. May admit and/or discharge patients for obstetrical care according to the aforementioned collaborative agreement and the aforementioned delineation of patient care services.

e. May serve without vote on appropriate Medical Staff committees, as appointed by the Chief of Staff, and may be invited to attend Medical Staff meetings, and may, as a condition of continued clinical privileges, be required to attend meetings that involve the clinical review of patient care in which they participated.

f. Shall be invited to all general meetings of the Department of Obstetrics and Gynecology and may attend without vote.

4. Designated Physician Supervisor

The Advanced Practice Provider must have a designated physician supervisor, who must be a current member of the Medical Staff in good standing, be currently licensed in the State of Florida and function only within the scope of his/her license. These guidelines cover the categories including:

a. Advanced Registered Nurse Practitioner (APRN): Registered Nurse, licensed by the State of Florida with advanced clinical experience and national certification to the extent required by state statute and department rules/regulations. Performs patient care services under the supervision of a physician and within the scope of practice as defined by Chapter 464-.012 F.S. and Chapter 64B9-4.010 F.A.C. As required by Florida Law, an APRN shall only perform patient care functions within the framework of an established protocol between the APRN and a Florida licensed physician or dentist. The degree and method of supervision shall be specifically identified in the written protocol. The original protocols must be filed with the Department of Health at the time of license renewal and a copy shall be kept at the site of practice at Tampa General Hospital together with a copy of the notice required by Section 458.348(1) F.S.

b. Certified Nurse Midwife (CNM): An APRN, licensed by the State of Florida with advanced clinical experience and national certification to the extent required by state statute and department rules/regulations. Performs patient care services under the supervision of a physician and within the scope of practice as defined by Chapter 464-.012F.S. and Chapter 64B9-4.010 F.A.C. As specified by department approved protocol, a CNM may accept and provide independent care to those non-Medicare patient mothers who are expected to have a normal pregnancy, labor, and delivery. A CNM may provide collaborative prenatal and postpartum care to pregnant women not at low risk in their pregnancy, labor and delivery, within a written protocol of a physician member of the medical staff currently licensed under Chapter 458 or Chapter 459, who shall maintain supervision for directing the specific course of medical treatment. The degree and method of supervision shall be specifically identified in the written protocol. The original protocol must be filed with the Department of Health at the time of license renewal and a copy shall be kept at the site of practice at Tampa General Hospital together with a copy of the notice required by Section 458.348(1) F.S. The CNM may participate directly in-patient care management within the protocol agreement and under the general supervision and direction of a medical staff member in the Department of Obstetrics and Gynecology.

c. Certified Registered Nurse Anesthetist (CRNA): An APRN, currently licensed and practicing in the State of Florida with advanced clinical experience and national certification to the extent required by State statutes and department rules/regulations. Performs patient care services under the supervision of a physician member of the Medical Staff with privileges in the Department of Anesthesiology and within the scope of practice as defined by Chapter 464-.012 F.S. and Chapter 64B9-4.010 F.A.C. As required by Florida Law, a CRNA shall only perform patient care functions within the framework of an established protocol between the CRNA and a licensed physician. The

degree and method of supervision shall be specifically identified in the written protocol. The original protocols must be filed with the Department of Health at the time of license renewal and a copy shall be kept at the site of practice at Tampa General Hospital together with a copy of the notice required by Section 458.348(1) F.S.

d. Physician Assistant (PA): Physician Assistant, licensed by the State of Florida with completion of a specific training program, clinical experience and successful completion of national certification to the extent required by State statutes and department rules/regulations. Performs patient care services under the supervision of a physician and within the scope of practice for patient care and supervision as defined by Chapter 458.347-348 or 459.022.

Section B. Supervision of Advanced Practice Providers

The control and personal direction exercised by the physician over the patient care services provided by the APP is the direct responsibility of the supervising physician. The supervising physician may delegate only those tasks or procedures to the APP, which are consistent with Florida Law and are within the scope of services identified in the collaborative protocol and are those patient care services for which the APP is qualified by training and/or experience and is knowledgeable, qualified and privileged, to perform. The decision to permit the APP to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the risk of morbidity and mortality to the patient and within the scope of patient-care services granted to the APP at Tampa General Hospital.

1. Primary Physician Supervisor: A physician who is designated in written agreement in the practitioner's credential file as having a primary responsibility for directing and supervising the APP.

2. Physician Supervisor of Physician Assistant (PA): A physician holding an unrestricted license to practice medicine in Florida or meets an exception as outlined under Florida Statute 458.003 or 455.02, who is a member of the Medical Staff of Tampa General Hospital and approved as a supervising physician by the Department of Health of the State of Florida, and who must supervise the activities of the PA. The scope of supervision shall be consistent with Chapter 480 or 489 F.S.

3. Physician Supervisor of Nurse Practitioner (APRN, CRNA, CNM): A physician holding an unrestricted license to practice medicine in Florida or meets an exception as outlined under Florida Statute 458.003 or 455.02, who is a member of the Medical Staff of Tampa General Hospital with unrestricted privileges for admitting and clinical privileges in the nurse's specialty area, and must supervise the Nurse Practitioner. The scope of supervision shall be consistent with Chapter 464 F.S. and Chapter 64B9 F.A.C.

4. Physician Supervisor of APP Engaged in Prescriptive Practice: A physician holding an unrestricted license to practice medicine in Florida or meets an exception as outlined under Florida Statute 458.003 or 455.02, who is a member of the Medical Staff of Tampa General Hospital, who must supervise the APP engaged in prescriptive practice. Supervision must be in accordance with applicable Florida Statutes. The supervising physician shall:

   a. Hold a valid registration(s) to issue written or oral prescriptions or medication orders for controlled substances from the US Drug Enforcement Administration (DEA).

   b. Review and provide direction to the APPs prescriptive practice periodically.

Section C. Levels of Supervision

1. Personal supervision. A physician must be in attendance in the room during the performance of the procedure.

2. Direct supervision. Physical presence of the supervising physician on the premises so that the supervising physician is immediately available to furnish assistance and direction throughout the performance of the procedure to the APP when needed. It does not mean that the physician must be present in the room when the procedure is performed

3. General Supervision: Under the supervising physician's overall direction and control but he physician's presence is not required during the performance of the procedure. Easy availability of the supervising physician to APP, which includes the ability to communicate by telecommunications. The supervising physician must be within reasonable physical proximity.

Section D. Procedure for Approval of a New Category of Advanced Practice Provider

A request to establish a new Advanced Practice Provider category must be submitted in writing to the Credentials Committee through the Department of Medical Staff Services. This request must include:

- A statement outlining the reason for the new category
- The statement of qualification required as indicated below
- The scope of practice description

The request will be reviewed, following appropriate input from the respective department/section chief. The chief shall transmit his/her recommendation on the category, the statement of qualifications and the scope of practice to the Credentials Committee and then to the Medical Executive Committee. Additional information may be required from the requestor or the respective department/section chief. If the recommendation from the Credentials Committee or the Medical Executive Committee is not unanimous, the nature of and reason for the dissenting view must be documented and transmitted with the majority's recommendation. The Board shall have the ultimate decision, based on the recommendation of the Medical Staff, for approving a new category.

Section E. Qualifications of Advanced Practice Providers, Physician First Assistants, and Non-Physician First Assistants

Every APP, PFA, and Non-Physician First Assistant who applies for or is exercising privileges must at the time of initial application for authorization to provide patient care services, and if approved, continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and the Hospital that the following qualification and any additional qualifications as are set forth for the particular category of APP, PFA, or Non-Physician First Assistant:

1. Licensure: Current licensure, registration, certification or such other credential as may be required by Florida law.

2. Professional Education and Training: As defined on the scope of practice description developed for each specified category.

3. Experience and Professional Performance: Current experience and results, documenting the ability to provide patient care services at an acceptable level of quality and efficiency in the hospital where specified services are or will be provided. The applicant will provide three professional references that provide an informed opinion of the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism, "Practice based learning and System Based Practice". If the applicant is a new graduate, one reference should be the Program Director. One reference should be from someone in the same professional discipline.

4. Cooperativeness: Ability to work cooperatively with others in the hospital environment, specifically to include refraining from conduct which over time constitutes a pattern of disruption such as to adversely affect the quality or efficiency of patient care services in the Hospital.

5. Professional Ethics and Conduct: To be of high moral character and to adhere to generally recognized standards of ethics relevant to the specific discipline.

6. Health Status: Have the ability to perform the patient care services requested, unless reasonable accommodations can be made for any impairment consistent with the interests of sound patient care. The APP applicant requests their Program Director, personal physician, or another APP credentialed at Tampa General Hospital to confirm their ability to perform their scope of practice. In the event of any physical or mental impairment, the APP shall promptly notify the Senior Vice President and Chief Medical Officer, Chief of Staff or other Medical Staff Officer so that a determination can be made as to whether or not there is a reasonable accommodation that can be made for the impairment that will permit the APP to continue to exercise his/her patient care services. The Practitioner Health Advisory Committee may be consulted.

7. Substance/Chemical Abuse: To be free from use of any type of substance or chemical that interferes with or presents probability of interfering with the APP's or PFAs ability to satisfy any of the qualifications required or his/her ability to perform all of the specified patient care services requested or granted.

8. Corporate Compliance: Practitioners must have never been convicted of, or entered a plea of guilty or no contest to, any felony unless an exception is made following review by the Credentials Committee, recommendation by the Executive Committee, and approval by the Board. No exception shall be made for any felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child, elder or other).

Section F. Communication Skills

Ability to read, write and communicate the English language in an intelligible manner and to prepare any authorized medical records entries and the required documentation in a legible manner.

Section G. Professional Liability Insurance

APPS and PFAs must have professional liability insurance coverage issued by a recognized company (authorized to do business in Florida) and of a type and in an amount equal to or greater than the limit established by the Board. It is encouraged that Certified Nurse Midwives also participate in the Florida Birth-Related Neurological Injury Compensation Association (NICA).

Non-Physician First Assistants are not required to have professional liability insurance.

Section H. Effect of Other Affiliations

No APP, PFA, or Non-Physician First Assistant shall be automatically entitled to specified services merely because:

1. He is authorized to practice in this or in any other state

2. He is a member of any professional organization

3. He is certified by a board

4. He had, or presently has, privileges to perform specified services at another health care facility or practice setting

5. He is or is about to be affiliated with a practitioner or another APP who is, or with a group of practitioners or APP's affiliated with this hospital through employment, contract, medical staff appointment or otherwise.

Section I. Prerogatives of Advanced Practice Providers, Physician First Assistants, and Non-Physician First Assistant

The prerogatives of an APP, PFA and Non-Physician First Assistant are to:

1. Perform such services as are defined by the Board, privileges granted by the Board, and consistent with any limitations governing the APP, PFA and Non-Physician First Assistant practice in the Hospital and any other medical staff or hospital policies.

2. APPs and PFAs may serve on committees, if so appointed. Non-Physician First Assistants are not eligible to serve on Medical Staff committees.

3. Attend, when invited, clinical meeting of the department or other clinical units when appropriate to his/her discipline.

4. Attend educational meetings of the department or other clinical units of the hospital.

Section J. Limitations of Advanced Practice Providers and Physician First Assistants and Non-Physician First Assistant

Advanced Practice Providers, Physician First Assistants and Non-Physician First Assistant ARE NOT:

1. Eligible to become members of the Medical Staff

2. Eligible to vote in meetings of, or hold office on the Medical Staff except as otherwise stated in the Medical Staff Bylaws

3. Eligible for admitting privileges (except for CNMs)

Section K. Obligations of Advanced Practice Providers, Physician First Assistants and Non-Physician First Assistant

Each Advanced Practice Provider, Physician First Assistant and Non-Physician First Assistant SHALL:

1. Provide patient care services at the level of quality and efficiency professionally recognized as the appropriate standard of care by the Medical Staff.

4. Participate in the quality assessment/improvement program activities appropriate to his/her discipline and in discharging such functions as may be required from time to time.

5. Abide by the applicable sections of the Medical Staff Bylaws, Rules and Regulations and related APP and PFA policies/procedures, all other policies of the Medical Staff and Hospital and Florida Statutes.

8. Provide to the Department of Medical Staff Services evidence of submission of established protocols and updates to the Department of Health as required by law.

9. Immediately notify the Chief Medical Officer of

a. any criminal charges brought against the APP, PFA, or Non-Physician First Assistant (other than minor traffic violations)

b. any change in the status of his/her license/certification to practice,

10. Perform only those services that he/she is licensed and privileged to perform.

11. Failure to satisfy any of these obligations is grounds, as warranted by the circumstances, for termination or non-renewal of specified patient care services or such other Corrective action as deemed appropriate.

Section L. Additional Obligations of Advanced Practice Providers and Physician First Assistants

Each Advanced Practice Provider and Physician First Assistant SHALL:

1. Provide or arrange for appropriate and timely coverage and care of patients for whom he/she is responsible.

2. When necessary and as appropriate, notify the principal attending physician of the need to arrange for a suitable alternative for care and supervision of patient.

3. Prepare and complete in a timely fashion, as appropriate and authorized those portions of the patient's medical records documenting services provided and any other required records.

4. Provide to the Department of Medical Staff Services evidence of current Florida licensure/Certification, and professional liability insurance coverage at time of renewal. Provide to the Department of Medical Staff Services evidence of current professional liability insurance coverage at time of renewal.

5. Immediately notify the Chief Medical Officer of:

   a. any change made or formal action initiated that could result in a change in the status of his/her license/certification to practice, professional liability insurance coverage, all changes in employment or affiliation relationships involving a termination, disciplinary action or reduction in specified services with a physician identified as one who supervises the APP, affiliation with specified services at another institution where he provided services

   b. any change in status of current or initiation of new malpractice claim involving professional performance, and any change in health status that could affect his/her ability to perform safe and sound patient care.

Section M. Scope of Practice for Advanced Practice Providers

May provide patient care services within the limits of their professional skills and ability. Degree of participation in patient care shall be determined according to established protocol and/or delineation of privileges reviewed and signed by the Chief of the Department/Section and approved by the Credentials Committee, Medical Executive Committee and Board within the scope of applicable legislation of the State of Florida.

Limitation may be placed on the APPs authorized scope of practice in the Hospital as deemed necessary either for the efficient and effective operation of the hospital or any of the department or services, or for management of personnel, services and equipment or for quality or efficient patient care as otherwise deemed to be in the best interest of patient care in the hospital. Granting of any patient care services does not exempt the supervising physician from total responsibility for the care of the patient, including timely completion and authentication of all medical record documentation.

Section N. Scope of Practice for Physician First Assistants

Physician First Assistants scope of practice is limited to surgical first assistant duties & privileges as granted.

Section O. Scope of Practice for Non- Physician First Assistants

Non-Physician First Assistants scope of practice is limited to surgical first assistant duties & privileges as granted.

Section P. Advanced Practice Provider Guidelines/Protocols

APRN (Includes CRNA, CNM):

In accordance with the Nurse Practice Act, Florida Statute, Chapter 464; Chapter 458.348(1); Chapter 455.694 and Chapter 64B9-4.010 at the initiation of a practice relationship between a Florida-licensed physician or dentist and an APRN, a practice protocol must be established. The practicing APRN must file the protocol with the Medical Staff Office and if practicing offsite, maintain a copy at the location where the APRN practices. Alterations or amendments that do not require Medical Staff approval should be signed by all parties and filed with the Medical Staff Office with 30 days.

The protocol should include at least the following:

1. Parties to Protocol

    a. APRN – name, home address, APRN certificate number, contact telephone number.

    b. Supervising (physician or dentist) – should list one primary physician or dentist with Name, address, license number and DEA number.

2. Nature of Practice

    a. list practice address including primary and satellite sites.

3. Description of duties and management areas for which the APRN is responsible:

    a. the conditions for which therapies may be initiated

    b. the treatment that may be initiated by the APRN, depending on patient condition and judgment of the APRN

    c. drug therapies that the APRN may prescribe, initiate, monitor, alter or order)

4. Description of the duties of the physician or dentist (which shall include consultant and supervisory arrangements in case the physician and dentists is unavailable). Additional physicians or dentists with whom the APRN may consult, refer to, or collaborate with may be listed as well.

5. Specific conditions and a procedure for identifying conditions that require direct evaluation or special consultation by the physician or dentist.

6. Signature of involved parties to include name, credentials, license number(s), DEA number and date of signing. The original dated page should be sent to the Board of Nursing for initial protocol, subsequent annual review and any amendments or changes to the protocol. A copy shall be provided and maintained in the Credential file and at the practice site at Tampa General Hospital.

7. If there are no changes to the protocol, only a dated signature page is needed with a statement that there have been no amendments or changes since the last submission.

8. The supervising physician is responsible for submitting a notice to the Board of Medicine that they have entered into a supervisory relationship with an APRN.

PA/APRN

In accordance with Florida Statute 458.489, when a physician enters into a formal supervisory relationship, which relationship contemplate the performance of medical acts, or when a physician enters into an established protocol with an APRN, which protocol contemplates the performance of medical act, the physician shall submit notice to the Board of Medicine. The notice shall contain a statement of the following:

1. Name and professional license number of physician and address noting he/she has entered into formal supervisory relationship or an established protocol with identified individuals.

2. Notice shall be filed within 30 days of entering into the relationship or protocol. Notice also shall be provided within 30 days after the physician has terminated any such relationship or protocol.

Section Q. Processing the Application for Privileges

It is the burden of the PFA, the Non-Physician First Assistant, and APP and his/her supervising physician, if applicable, to produce adequate information for a proper evaluation of the applicants experience, training, current competence, ability to work cooperative with others, ability to perform the patient care services requested, identity, and to resolve any doubts about the qualifications for specific services and of satisfying any reasonable requests for information or clarification made by the Medical Staff.

As part of the review process, Non-Physician First Assistant, CSTFA applications are first reviewed by the Professional Nursing Credentialing and Authorization Committee with sign-off recommended approval by the CNO before the application may be provided to the respective Department Chief for review and signature.

RNFA, APRN and PA applications, are first reviewed by the Advance Practice Provider Credentialing and Authorization Committee (APPCAC). The APPCAC will review evidence of character, professional competence, ability to perform the privileges requested, qualifications and ethical standing of the applicant before the application may be provided to the respective Department/Section Chief for review and signature. The APPCAC shall provide a report to the Credentials Committee on all RNFA, APRN and PA applicants.

PFA applications are reviewed by the Chief of the Department of Surgery for review and signature.

Application for clinical privileges, review of performance and revocation or reduction in privileges shall follow the same procedure as outlined in Article XV of these Bylaws, with the exception that verification is limited to a five (5) year timeframe. Privileges for APPs shall automatically terminate upon termination of the APPs supervising physician unless another Medical Staff member has accepted the responsibility for supervision in writing and the necessary documents have been updated and approved. Non-Physician First Assistants, Physician First Assistants and Advanced Practice Providers, with the exception of nurse midwives, have no admitting privileges. APPs may attend patients only if requested by a member of the Medical Staff. The attending physician is ultimately responsible for overall medical care of the patient.

Section R. Removal Procedures

1. Advanced Practice Providers and Physician First Assistants are **entitled** to the hearing procedures set forth in Article XVI, Corrective Action with the exceptions noted below for APPs.

2. Automatic Termination: The Advanced Practice Provider's privilege to function at the Hospital shall be automatically terminated without any right to a hearing or review or grievance upon the first of the following events to occur:

   a. Termination of employment with the Advanced Practice Provider's employer, for any reason.

   b. Filing of a written statement by the designated (supervising) physician with the President of the Hospital that he or she will no longer be responsible for the supervision of the Advanced Practice Provider.

   c. Revocation by appropriate authorities of the license or certificate of the Medical Staff affiliate.

   d. Termination or suspension of the designated physician's appointment on the Medical Staff.

3. Corrective Action

   Advanced Practice Providers and Physician First Assistants may have their approved activities and procedures reduced, restricted, supervised, suspended, or terminated in their entirety, in accordance with Articles XVI and XVII (Corrective Action, Fair Hearing and Appellate Review). An Advanced Practice Provider may be added to the Investigative Committee by the Chief of Staff, without vote.

Section S. Reappraisal and Re-delineation of Privileges

All Advanced Practice Providers, physician first assistants, and non-physician first assistants will be subject to the FPPE and OPPE requirements of the Medical Staff and will be evaluated at the time of reappointment.

The appropriate Department or Section Chief will perform ongoing scope of practice review as data becomes available. The basis of the ongoing review could be direct observation, medical record reviews, peer to peer reference review, and outcomes data related to the APPs supervising physician.

If the Department Chief has concerns about a Physician First Assistant or Non-Physician First Assistant not meeting their scope of practice standards, a focused review will be performed. The basis of the focused review will be direct observation and peer to peer reference. The time of the focus review will be such to allow the Department Chief time to determine whether or not the PFA or the Non-PFA meets the scope of practice standards. If the focused review demonstrates the PFA or Non-PFA does not meet the scope of practice standards, they are entitled to the hearing procedures set forth in Article XVII of the Bylaws.

If the Department or Section Chief has concerns about an Advanced Practice Provider not meeting their scope of practice standards, a focused review will be performed in conjunction with the supervising physician. The basis of the focused review will be direct observation, medical record review, and peer to peer reference. The time of the focus review will be such to allow the Department or Section Chief time to determine whether or not the APP meets the scope of practice standards. If the focused review demonstrates the APP does not meet the scope of practice standards, they are entitled to the hearing procedures set forth in Article XVII of the Bylaws.

The Department or Section Chief will perform a focused review of new privileges granted through the credentialing process. That review can be by direct observation, medical record review, and peer to peer references. The time of the review will be sufficient to determine the APP, PFA, or Non-PFA competency with the privilege. If the review does not confirm competency, the Chief can have an educational and/or mentoring plan as part of the summary of the review.

If the ongoing scope of practice review does not identify concerns, the Department or Section Chief will obtain three peer to peer references prior to the biannual reappraisal. The references will provide an informed opinion of the APP's, PFA's, or Non-PFA's current knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism, scope of practice learning and system based practice.

The Department Chief will submit a recommendation to the Credentials committee regarding the APP's, PFA's, or Non-PFA's renewal of privileges.

Medical Staff Bylaws are:

ADOPTED by the active Medical Staff of Tampa General Hospital: 09/20/2021

APPROVED by the Board, the Florida Health Sciences Center, Inc.: 09/28/2021