MEDICAL STAFF

BYLAWS

OF THE

ORLANDO
HEALTH®

ODSAW
MEDICAL STAFF

1414 KUHL AVENUE
ORLANDO, FL 32806

MARCH 2022

As of (DATE) Medical Staff Bylaws
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BYLAWS OF
THE MEDICAL STAFF OF
ORLANDO HEALTH

DEFINITIONS

1. **Board Of Directors or Board** – means the Board of Directors of Orlando Health, Inc., and its designees.

2. **Chief Executive Officer** – means the President of Orlando Health, Inc., and his or her designee.

3. **Day(s)** – means calendar day(s).

4. **Governing Documents** – means the Orlando Health Medical Staff Bylaws, Organizational Policy, Allied Health Policy and Procedure, and Rules and Regulations.

5. **Hospital(s)** – means the ODSAW Hospitals.

6. **Hospital Facility** – means an individual Hospital Facility within the Hospitals. Hospital Facilities include Orlando Regional Medical Center, Dr. P. Phillips Hospital, South Seminole Hospital, Arnold Palmer Hospital for Children, and the Winnie Palmer Hospital for Women and Babies. The addition of new Hospital Facilities to this section will be considered a technical amendment of these Bylaws.

7. **Medical Executive Committee or MEC** – means the Medical Executive Committee of the Medical Staff.

8. **Medical Staff** – means the Orlando Health Medical Staff, consisting of the Medical Staff of the ODSAW Hospitals, and includes all physicians, dentists, podiatrists and psychologists who have been granted Medical Staff membership and Clinical Privileges at the Hospitals through the organized Medical Staff process that is subject to the Medical Staff Bylaws of the Orlando Health Medical Staff. It also includes certain physicians, dentists, podiatrists, and psychologists who have been granted Medical Staff membership but who do not have Clinical Privileges (i.e., Affiliate and Honorary Medical Staff members).

9. **Medical Staff Bylaws** – means the Medical Staff Bylaws of the Orlando Health Medical Staff.

10. **Notice** – means a written communication sent by certified or registered mail, return receipt requested, unless otherwise specifically stated in these Bylaws.

11. **Orlando Health or OHI** – means the Orlando Health, Inc. healthcare system, consisting of multiple wholly-owned and/or affiliated Hospitals, rehabilitation centers, medical practices, outpatient surgery centers, urgent care centers, imaging centers, and other wholly-owned and/or affiliated entities.

12. **ODSAW Hospitals** – means Orlando Regional Medical Center, Dr. P. Phillips Hospital, South Seminole Hospital, and Arnold Palmer Medical Center and Winnie Palmer Hospital
for Women & Babies, which together constitute a separately certified multi-campus Hospital within Orlando Health.

13. **Patient Contact** – means any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital, including provider-based outpatient facilities. Patient contacts shall not include referrals for diagnostic testing to be done by other Practitioners or Hospital personnel.

14. **Practitioner** – means a physician, dentist, podiatrist and/or psychologist.

15. **Professional Review Action** – means an action or recommendation of a health care entity that is taken in the course of a Professional Review Activity, based on the professional competence or professional conduct of an individual health care Practitioner which affects or could affect adversely the health or welfare of a patient or patients, and that adversely affects or may adversely affect a Practitioner’s Clinical Privileges or Medical Staff membership, as set forth in the Health Care Quality Improvement Act of 1986 (HCQIA).

16. **Professional Review Activity** – means an activity of a Hospital to determine whether a Practitioner may have Clinical Privileges or Medical Staff membership, and/or to determine the scope or conditions of such privileges or membership, or to change or modify such privileges or membership. A Professional Review Activity includes credentialing, privileging, reappointment, practice evaluations, collegial intervention, Investigations and Medical Staff Hearings.

17. **System Chief of Staff and System Vice Chief of Staff** – means the Chief of Staff and Vice Chief of Staff of the ODSAW Hospitals. The System Chief of Staff is responsible for the organization and conduct of the entire Medical Staff.

18. **Hospital Chief of Staff and Hospital Vice Chief of Staff** – means the Chief of Staff and Vice Chief of Staff of an individual ODSAW Hospital.
ARTICLE 1

ORGANIZATION, OPERATION AND PURPOSE

The purpose of the Medical Staff of Orlando Health, acting through its duly appointed and functioning Clinical Departments and Medical Staff Committees and in accordance with these Bylaws, is:

1. To monitor and evaluate the quality of medical care in the Hospitals and to make recommendations thereon to the Board so that all patients admitted to or treated at any of the Hospitals, departments or services of the Hospitals shall receive optimum quality care in a cost-effective manner.

2. To provide a forum and establish procedures wherein the Medical Staff may review, evaluate, and discuss matters of a medical and/or administrative nature with the administration, Board, and other associations, agencies, and organizations.

3. To maintain self-governance of the Medical Staff.

4. To make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff; to recommend to the Board the Clinical Privileges each applicant shall have in the Hospitals and to review and evaluate such Clinical Privileges on a continuing basis once granted; to recommend to the Board any appropriate action that may be necessary in connection with any member of the Medical Staff or Practitioner with Clinical Privileges, to ensure that all individuals with Clinical Privileges perform according to current clinical competence.

5. To establish Rules and Regulations, an Organizational Policy, credentialing policies and other policies and procedures to govern the actions and professional responsibilities of members of the Medical Staff.

6. To provide an appropriate educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized from time to time.

7. To organize itself to accomplish these purposes by placing responsibility for operational concerns with the various Hospitals while assuring uniformity of direction and purpose and maintaining a single standard of performance through a single MEC with representation from each Hospital.
ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

PART A: ACTIVE STAFF

1. Those physician, dentist, and podiatrist Medical Staff members who have a minimum of twelve (12) patient contacts at the Hospitals annually, and who:
   a. are able to meet all clinical and on-call obligations set forth in these Bylaws and any and all other Medical Staff and Hospital policies and/or procedures; and
   b. except for members of the Telemedicine Staff, reside and maintain a medical practice close enough to the Hospital to be able to provide continuous care for the Practitioner’s patients and respond to on-call obligations consistent with Medical Staff rules and policies. The required geographic proximity, which is determined by the Medical Executive Committee upon approval by the Board, may vary depending on the Practitioner’s specialty and privileges, Medical Staff category, and feasibility of arranging alternative coverage.
   c. agree to assume all of the functions and responsibilities of membership on the Active Medical Staff, including acceptance of teaching assignments, participation in call, and participation in peer review activities and, when required by the applicable Clinical Department Chairperson, the System Chief of Staff, or the applicable Hospital Chief of Staff, care of any patient, including, but not limited to, emergency care, consultations, and admissions.

2. Active Staff members are entitled to vote, hold office, serve on Medical Staff Committees, and serve as Chairperson or Vice Chairperson of such Committees, and are encouraged but not required to attend Medical Staff meetings.

PART B: SENIOR STAFF

1. Those physician, dentist, and podiatrist Active Members who apply for Senior Staff and who have either:
   a. been on the Active Medical Staff for not less than twenty (20) consecutive years; or
   b. been on the Active Staff for a minimum of five (5) consecutive years and have reached the age of sixty (60).

2. Senior Staff Members are members are entitled to vote, hold office, serve on Medical Staff Committees, and serve as Chairperson or Vice Chairperson of such Committees, and are encouraged but not required to attend Medical Staff meetings.

3. Senior Staff members are generally exempt from on-call obligations, teaching assignments and participation in peer review activities, but may be required by the applicable Clinical Department Chairperson, the System Chief of Staff, or the applicable Hospital Chief of Staff to assume additional functions and responsibilities including care of any patient, emergency
care and consultation, teaching assignments, participation in call, and participation in peer review activities.

PART C: COURTESY STAFF

1. Those physician, dentist, and podiatrist members who have fewer than twelve (12) patient contacts at the Hospitals annually.

2. Courtesy Staff members are encouraged to attend Medical Staff meetings and to assume Medical Staff Committee responsibilities but may not vote or hold office or be Chairperson or Vice Chairperson of their Clinical Department or a Medical Staff Committee.

3. Courtesy Staff members are generally exempt from on-call obligations, teaching assignments and participation in peer review activities, but may be required by the applicable Clinical Department Chairperson, the System Chief of Staff, or the applicable Hospital Chief of Staff, to assume additional functions and responsibilities including care of any patient, emergency care and consultation, teaching assignments, participation in call and participation in peer review activities.

4. A Courtesy Staff member will be transferred to Active Staff at reappointment if he or she has had twelve (12) or more patient contacts within a one-year period during the last term of appointment. Courtesy Staff members who wish to transfer to Active Staff prior to the reappointment period may submit a written request for a category change to the Medical Staff Office. The request will be submitted to the Department Chairperson, who may make a recommendation for approval to the Credentials Committee. The Credentials Committee will review the request and make a recommendation to the MEC for approval by the Board.

PART D: AFFILIATE STAFF

1. Those physician, dentist, podiatrist, and psychologist members who practice in the community but who do not admit patients to the Hospitals and/or do not treat patients in the Hospitals. The primary purpose of the Affiliate Staff category is to permit these Practitioners to access hospital services for their patients upon referral to the Hospitals.

2. For patients referred to a Hospital by an Affiliate Staff member, the member may only review medical records, follow a patient’s progress, confer with a patient’s treating physician(s), and, with the approval of a patient’s treating physician, observe diagnostic or surgical procedures.

3. Affiliate Staff members have no Clinical Privileges and may not make entries in a patient’s medical records. Affiliate Staff members may serve on Medical Staff Committees but cannot vote or hold office or be Chairperson or Vice Chairperson of their Clinical Department or a Medical Staff Committee. Affiliate Staff members are encouraged but not required to attend Medical Staff meetings.

PART E: TELEMEDICINE STAFF

1. Telemedicine Staff members are those physicians, dentists, and podiatrists who are contracted by Orlando Health and/or a Hospital to provide diagnosis and treatment to patients in a Hospital remotely, solely through telecommunications links.
2. Telemedicine Staff members may not vote and may not hold office or serve as Clinical Department or Medical Staff Committee Chairperson or Vice Chairperson. They may be required by contract to assume certain responsibilities and functions, including but not limited to emergency care and consultation, teaching assignments, and participation in peer review activities.

PART F: PSYCHOLOGY STAFF

1. Psychologists may not admit or discharge patients. Psychologists are encouraged but not required to attend Medical Staff meetings and may serve on Medical Staff Committees but cannot vote or hold office nor be Chairperson or Vice Chairperson of a Clinical Department or Medical Staff Committee.

2. Psychologists may be required by the applicable Clinical Department Chairperson, the System Chief of Staff, or the applicable Hospital Chief of Staff to assume additional functions and responsibilities, including patient care and participation in peer review activities.

PART G: HONORARY STAFF

1. The Honorary Medical Staff shall consist of physicians, dentists, podiatrists and psychologists who are not active in the Hospitals and who are honored by emeritus positions. These may be physicians, dentists, podiatrists and psychologists who are retired from the Active or Senior Staff and active hospital practice at the Hospitals, or physicians, dentists, podiatrists and psychologists of outstanding reputation.

2. Honorary Staff members have no assigned duties or responsibilities and are not eligible to vote or hold office or be Chairperson or Vice Chairperson of a Medical Staff Committee. Honorary Staff members do not have Clinical Privileges, will not be required to reappoint, and do not need to maintain a current Florida medical practice license.
ARTICLE 3
MEDICAL STAFF MEMBERSHIP

PART A: QUALIFICATIONS FOR APPOINTMENT AND REAPPOINTMENT

1. Membership on the Medical Staff of Orlando Health is a privilege that shall be extended only to professionally competent physicians, dentists, podiatrists, and psychologists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. All persons practicing medicine, dentistry, podiatry, and psychology in the Hospitals, unless exempted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff.

2. To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the granting of Clinical Privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested as set forth in the Medical Staff credentialing policies. Additional details associated with this Article are contained in the Medical Staff credentialing policies. In the event of a conflict between a credentialing policy and these Bylaws, the terms of these Bylaws will prevail.

3. Each period of appointment to the Medical Staff will be for no more than two (2) years.

4. Practitioners must meet the following qualifications to be qualified for membership on the Medical Staff:

a. Have a current, unrestricted license to practice in the State of Florida that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees;

b. Can document their adherence to the ethics of their profession and their good reputation and character;

c. Can document their background, experience, training, and demonstrated current competence to perform specific Clinical Privileges requested, if any, and their ability to work with others, sufficiently to convince the Hospital(s) that all patients treated by them in the Hospital(s) will receive a high quality of care;

d. Meet the requirements of the Clinical Department to which they are applying; and

e. Meet the following Board Certification Requirements:

i. Board Certified in the specialty or subspecialty in which privileges are requested by a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by the American Board of Podiatric Surgery, the American Board of Professional Psychology, the American Board of Pediatric Neuropsychology or American Board of Professional Neuropsychology, the American Board of Oral and Maxillofacial Surgery, American Board of General Dentistry or American Board of Pediatric Dentistry; OR
Eligible to be admitted to the certification process of a Board in the preceding paragraph in the specialty or subspecialty in which privileges are requested and who can achieve Board Certification within the eligibility period set by the applicable Board; or six (6) years following completion of the training specified by the applicable Board, whichever is earlier.

ii. A physician, dentist, podiatrist or psychologist who does not achieve Board Certification within the eligibility period will automatically relinquish Medical Staff membership and Clinical Privileges without entitlement to a Medical Staff Hearing or Appeal unless a waiver to the Board Certification requirement is granted by the Board.

iii. Maintenance of Certification is not required for continuous reappointment, except as may be required to hold office, be chairperson or vice chairperson of a Clinical Department or as provided by a Clinical Privilege delineation form of the various Clinical Departments, or as required by law.

5. No physician, dentist, podiatrist or psychologist shall be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges in the Hospitals merely by virtue of the fact that he or she is duly licensed to practice medicine, dentistry, podiatry or psychology in Florida or any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or currently has, Medical Staff membership or privileges in another hospital.

6. In making determinations of eligibility for appointment, consideration may be given to patients' needs, the available Hospitals and resources, the ability of the Hospitals to provide adequate facilities and supportive services for the applicant and his or her patients, and utilization standards in effect at the Hospitals.

7. No physician, dentist, podiatrist, or psychologist may be denied membership on the basis of race, creed, color, national origin, religion, sex, or sexual orientation.

8. Acceptance of membership on the Medical Staff constitutes the agreement of the physician, dentist, podiatrist, or psychologist to:

a. Abide by the Principles of Medical Ethics of the American Medical Association, or the Code of Ethics of the American Dental Association, or the Code of Ethics of the American Osteopathic Association, or the Code of Ethics of their respective associations, whichever is applicable, including but not limited to providing for continuous care of patients and seeking consultation when necessary; and

b. Abide by all Bylaws, policies, and directives of the Hospital, and all Governing Documents and policies and procedures of the Medical Staff; and

c. Be bound by and comply with the Orlando Health Corporate Compliance Program and Code of Conduct as recognized business and practice patterns that comply with federal, state, and local laws, statutes, regulations, and rules; and

d. Notify the System Chief of Staff within fourteen (14) calendar days of:
1. any action taken against the Medical Staff member’s professional license, the imposition of terms of probation or limitation of practice, or disciplinary action by any state.

2. the termination, suspension, or lapse of the Medical Staff member’s Drug Enforcement Administration license.

3. the loss, suspension, or probation of Medical Staff membership or privileges or any other professional competence or disciplinary/ adverse action taken or pending at any hospital, other health care institution, or professional society.

4. the voluntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration) or voluntary limitation, reduction, or loss of Clinical Privileges at any other hospital or health care facility.

5. the commencement of any investigation, or the filing of charges, by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or any state.

6. the filing of a notice of intent or lawsuit against the Medical Staff member alleging professional liability, or the settlement of any medical malpractice claim or litigation by the Medical Staff member or by anyone in the Medical Staff member’s behalf.

7. a conviction of or pleading nolo contendere to any crime, including but not limited to a crime relating to health care.

8. the exclusion from or ineligibility for participation in federal or state health care programs.

9. the filing of a suit against the Medical Staff member alleging fraud or abuse involving any federal or state health care program.

10. the imposition of fines and/or penalties against the Medical Staff member in any case alleging fraud or abuse involving any federal or state health care program.

11. any other legal or regulatory filing and/or action that affects or may affect the Medical Staff member’s ability to practice his or her profession.

9. Medical Staff members who have contractual or employment relationships with Orlando Health will be governed by the provisions of their contracts and/or terms of employment as well as by the Governing Documents and Medical Staff policies and procedures. The terms of a Practitioner’s contract or employment relationship may not be less restrictive than but may waive or surrender any of the rights of, the Governing Documents and Medical Staff policies and procedures, and may limit the scope, location, time, or practice of the Practitioner.

10. For the benefit and convenience of patients and the community, all Medical Staff members will be listed on the Orlando Health website, in accordance with Orlando Health’s website policies and procedures.
PART B: CONDITIONS OF APPOINTMENT

1. Rights and Duties of Appointees. Initial appointments and reappointments to the Medical Staff are granted by the Board upon recommendation of the Credentials Committee and MEC. Appointment to the Medical Staff confers only those Clinical Privileges approved by the Board and shall require that each appointee comply with the Hospital and Medical Staff Bylaws, Rules and Regulations, Organizational Policy, credentialing policies and other policies and procedures, and assume all duties and responsibilities as required by the Hospital or Medical Staff.

2. Covering Practitioner Arrangements. All Medical Staff members with Clinical Privileges must have continuous coverage arrangements with a Practitioner on the Medical Staff with like Clinical Privileges at the Hospital(s). This arrangement must be documented in the Orlando Health Medical Staff Services Office. It is the member’s responsibility to notify the Medical Staff Services Office of any changes to covering Practitioner arrangements. This requirement may be waived by the Board upon recommendation of the Credentials Committee and MEC if exceptional circumstances exist.

3. Compliance with Florida Financial Responsibility Requirements. All Medical Staff members must continuously comply with Florida’s financial responsibility requirements and provide documentation of compliance to the Orlando Health Medical Staff Services Office. It is the member’s responsibility to notify the Medical Staff Services Office of any changes in this information.

4. Additional details associated with this Article are contained in the Medical Staff credentialing policies. In the event of a conflict between a credentialing policy and these Bylaws, the terms of these Bylaws will prevail.
ARTICLE 4

APPOINTMENT TO THE MEDICAL STAFF AND ACTIONS AFFECTING MEDICAL STAFF MEMBERS

PART A: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

1. Applications for appointment to the Medical Staff and for delineated Clinical Privileges shall be submitted on forms prescribed by the Board after consultation with the Credentials Committee. The application shall require detailed information concerning the applicant's professional qualifications including, but not limited to:

   a. the names of at least three (3) peers, at least one of whom is in the same specialty, who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's current professional competence and ethical character and ability to perform the privileges requested;

   b. information as to whether the applicant's Medical Staff appointment and/or Clinical Privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, or not renewed at any other hospital or health care facility;

   c. information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license have ever been suspended, terminated, or voluntarily relinquished, and whether there is any currently pending challenge to such licensure);

   d. information as to whether the applicant's membership in local, state, or national medical or professional societies have ever been suspended, terminated, or voluntarily relinquished, and whether there is any currently pending challenge to such membership;

   e. information concerning the applicant's malpractice history;

   f. proof of compliance with Florida's financial responsibility requirements;

   g. a consent to the release of information;

   h. a request for the specific Clinical Privileges, if any, desired by the applicant and documentation of compliance with the requirements for such Clinical Privileges as set forth in the applicable Clinical Privilege description;

   i. documented coverage arrangements with a current Medical Staff member with like privileges unless an exception is recommended by the Credentials Committee, Medical Executive Committee and approved by the Board; and,

   j. in addition to the above, applicants for the Telemedicine Staff must provide a list of all other hospitals at which they provide or have provided telemedicine services;

   k. any other information the Board may require.
2. Every application for staff appointment shall be signed by the applicant and shall contain:

   a. the applicant's specific acknowledgment of the obligation upon appointment to the Medical Staff to provide or make provision for continuous care and supervision to all patients within the Hospitals for whom he or she has responsibility;

   b. the applicant's agreement to abide by all such bylaws, Governing Documents, policies, and directives of the Hospital and Medical Staff, and including any and all regulatory and accreditation requirements as set forth by state and federal agencies and accrediting bodies;

   c. the applicant's agreement to accept committee assignments, emergency call, and such other reasonable duties and responsibilities as shall be assigned to him or her by the Medical Staff;

   d. a statement that the applicant has received and read a copy of such bylaws, Governing Documents policies, and directives of the Hospital and Medical Staff as are in force at the time of his or her application and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of his or her application without regard to whether or not the applicant is granted appointment to the Medical Staff and/or Clinical Privileges; and,

   e. a statement of the applicant's willingness to appear for personal interviews in regard to his or her application.

3. The applicant has the burden of producing adequate information for a proper evaluation of his or her current competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. The applicant has the burden of providing evidence that all the statements made and information given on the application are factual and true.

4. Statement of Release and Immunity from Liability. The following are express conditions applicable to any physician, dentist, podiatrist or psychologist during his or her appointment or reappointment to the Medical Staff. By applying for appointment to the Medical Staff and for Clinical Privileges the applicant expressly accepts these conditions during the processing and consideration of his or her application, regardless of whether the applicant is granted appointment to the Medical Staff and Clinical Privileges as well as for the duration of his or her appointment. To the fullest extent permitted by law, the applicant or appointee extends absolute immunity and release from liability to the Hospitals and its authorized representatives from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures involving the physician, dentist, podiatrist or psychologist performed, made, taken, or received by the Hospitals and its authorized representatives in good faith during the course of the business of the Hospitals specifically including, but not limited to, members of its Medical Staff by or from any third party concerning activities relating to, but not limited to:

   a. Applications for appointment or Clinical Privileges, including temporary Clinical Privileges;

   b. Periodic reappraisals undertaken for reappointment or for increase or decrease in Clinical Privileges;
c. Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation;

d. Peer review;

e. Proceedings for disciplinary or corrective action, including but not limited to suspension of Clinical Privileges and/or revocation of staff membership;

f. Precautionary suspension;

g. Hearings and appellate reviews;

h. Utilization and quality reviews;

i. Exclusion from federal or state healthcare programs or conviction of healthcare related crimes;

j. Other Hospital, departmental, service, or committee activities relating to the quality of patient care or the professional conduct of a physician, dentist, podiatrist or psychologist; and concerning matters or inquiries relating to a physician's, dentist's, podiatrist's or psychologist's professional qualifications, credentials, current clinical competence, character, ability to perform Clinical Privileges requested or granted, ethics, or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operation of this or any other hospital or health care facility, including otherwise privileged or confidential information.

k. Any act, communication, report, recommendation or disclosure, with respect to any such physician, dentist, podiatrist or psychologist performed or made in good faith and at the request of an authorized representative of the Hospitals or any other hospital or health care facility, for the purposes set forth in (1) above, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Hospitals and its authorized representatives, and to any third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. The applicant or appointee to the fullest extent permitted by law extends absolute immunity and release from liability to any third parties who supply information as set forth in this Section.

l. The Hospitals and its authorized representatives are specifically authorized to consult with the management and members of the Medical Staffs of other hospitals, health care facilities or institutions with which the applicant or appointee has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications.

m. The Hospitals and its authorized representatives are specifically authorized to inspect all records and documents that may be material to an evaluation of either the physician's, dentist's, podiatrist's or psychologist's professional qualifications or current competence to perform the Clinical Privileges the physician, dentist, podiatrist or psychologist requests or currently possesses, as well as of the physician's, dentist's, podiatrist's or psychologist's moral and ethical qualifications or
stability as they may directly or indirectly affect the individual's current competence, patient care, or the good operation of the Hospitals or any other health care facility.

n. The applicant or appointee specifically releases from any liability all representatives of the Hospitals, including its Medical Staff, for statements made or acts performed in good faith in evaluating the physician, dentist, podiatrist or psychologist for any of the purposes or reasons set forth in this section.

o. As used in this section, the term "Hospitals and its authorized representatives" means the Hospitals, the members of its Board and their appointed representatives, the Chief Executive Officer, the President, and their subordinates or designees, the Hospital's attorney and the Hospital attorney's partners, assistants or designees, and all members of the Medical Staff who have any direct or indirect responsibility for obtaining or evaluating the applicant's or appointee's credentials and/or acting upon the applicant's or appointee's application or conduct in the Hospitals.

p. As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships, corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospitals and its authorized representatives, or who have requested such information from the Hospitals and its authorized representatives, provided that such request is received in good faith and pertains to the subject matter set forth in this section.

PART B: PROCESS FOR PRIVILEGING AND CREDENTIALING (APPOINTMENT, REAPPOINTMENT AND REQUEST FOR EXPANSION OF CLINICAL PRIVILEGES)

1. Requests for privileges and completed applications are provided to the applicable Department Chairperson, who reviews the individual's education, training, and experience and prepares a form provided by the Medical Staff Office stating whether the individual meets all qualifications.

2. The Credentials Committee then reviews and discusses the Department Chairperson's assessment, the application, and all supporting materials and makes a recommendation to the MEC.

3. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a Medical Staff Hearing.

PART C: MODIFIED CREDENTIALING PROCESS FOR TEMPORARY PRIVILEGES, DISASTER PRIVILEGES, AND TELEMEDICINE PRIVILEGES

1. In the following situations, the standard process for credentialing applicants for appointment and/or Clinical Privileges may be modified, as set forth in detail in the Medical Staff credentialing policies:
a. When the Disaster Plan (see Hospital policy #1212) has been implemented and the Hospital Incident Command Center has been activated, the CEO, CMO, System Chief of Staff, or applicable Hospital Chief of Staff may use the modified credentialing process set forth in Policy 5873-8009 Credentialing Practitioners in a Disaster, to grant disaster privileges to a Practitioner after verification of the Practitioner’s identity and licensure. Subsequent verification of credentials will be conducted in accordance with Policy #5873-8009.

b. Upon the recommendation of the Department Chairperson and the System Chief of Staff, an applicant for initial Medical Staff membership and/or initial or increased Clinical Privileges who has a complete and clean application that has been verified and is awaiting review by the Credentials Committee, MEC and/or Board may be granted temporary privileges for no more than 120 days by the CEO or designee, acting on behalf of and as a subcommittee of the Board.

c. When an important patient care need exists, including locum tenens coverage, temporary privileges may be granted by the CEO or designee, acting on behalf of and as a subcommittee of the Board, after receiving the recommendation of the Department Chairperson and System Chief of Staff. In all cases involving important patient care needs, licensure and current clinical competence will be verified and the OIG sanctions list and NPDB will be queried prior to the granting of privileges. Practitioners who provide locum tenens services on a regular basis may be subject to additional verification requirements. Temporary Clinical Privileges for locum tenens or important patient care need may be granted for a maximum period of 120 days.

d. Temporary Clinical Privileges shall be granted for a specific period of time as warranted by the situation and expire at the end of the time period for which they are granted.

e. The CEO or System Chief of Staff may terminate an individual's temporary Clinical Privileges at any time. The appropriate Department Chairperson or, in the absence of the Department Chairperson, the Chief of Staff, shall assign to a member of the Medical Staff responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute member of the Medical Staff.

f. The granting of any temporary Clinical Privileges is a courtesy on the part of the Hospital and neither the granting, denial, or termination of such temporary Clinical Privileges shall entitle the individual concerned to any of the procedural rights provided in the Medical Staff bylaws with respect to hearings or appeals.

g. Emergency Action. In an emergency, any Medical Staff member as permitted by his or her license and regardless of Clinical Privileges, is permitted to do, and shall be assisted in doing everything possible to save the life of a patient in the Hospitals, including calling for any consultation. When an emergency situation no longer exists, such staff member must request the temporary Clinical Privileges necessary to continue to treat the patient. In the event such temporary Clinical Privileges are denied or the staff member does not request such privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition which could result
in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

h. Telemedicine privileges refer to privileges to provide diagnosis and treatment to patients in the Hospitals remotely solely through telehealth technology. Medical Staff members and other health care providers may evaluate, communicate, consult, confer, or discuss clinical issues and patient care with other physicians, health care providers and patients via telehealth technology without the need for telemedicine privileges.

i. Applicants for telemedicine privileges must be contracted with Orlando Health to provide telemedicine services and are eligible to apply only for those telemedicine privileges specific to their contract with Orlando Health.

ii. Telemedicine privileges shall automatically terminate upon termination of the contractual relationship with Orlando Health, with no recourse to the procedural rights provided in Article 7, unless otherwise specified by contract.

iii. Telemedicine privileges must be personally performed by the individual who has been granted such privileges. No person with telemedicine privileges may outsource, offshore, or otherwise subcontract the performance of telemedicine services.

PART D: INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

1. A Practitioner’s appointment and/or Clinical Privileges may be automatically relinquished without right to a Medical Staff Hearing or Appeal if an individual:

   a. fails to timely complete medical records in accordance with the Medical Staff Rules and Regulations;

   b. fails or ceases to satisfy any of the eligibility criteria for Medical Staff membership or Clinical Privileges (as set forth in these Bylaws, Medical Staff credentialing policies and/or the applicable Clinical Privilege delineation);

   c. fails to provide requested information within the timeframe established by the Hospital, Committee or Medical Staff leader(s) making the request;

   d. fails to attend a Mandatory Meeting;

   e. fails to obtain a fitness for practice or clinical competency evaluation, when requested;

   f. fails to comply with educational or training requirements (as set forth in Hospital or Medical Staff policy or as required by a Committee and/or the Board);

   g. is convicted or pleads guilty or no contest to any felony, or misdemeanor involving controlled substances, illegal drugs, Medicare, Medicaid or insurance or
healthcare fraud and abuse, or violence, or is subject to adverse action by a government agency, including but not limited to exclusion from federally funded programs;

h. makes a misstatement or omission on an application form or in conjunction with an application or professional practice evaluation activity;

i. remains on leave for longer than one year, unless an extension is granted by the Board upon the recommendation of the MEC;

j. fails to provide emergency department call coverage as scheduled;

k. is unable to be located due to failing to notify the Hospital of changes in essential contact information;

l. is an allied health practitioner (AHP) whose supervising Practitioner no longer maintains Medical Staff appointment or Clinical Privileges at the Hospital, for any reason, or the AHP fails for any reason to maintain an appropriate supervision relationship with a member of the Medical Staff.

2. Upon notice to the Practitioner or AHP, automatic relinquishment is effective immediately and continues until the matter is resolved or a request for reapplication or reinstatement has been acted upon by the Board, upon recommendation of the Credentials Committee and MEC. The Department Chairperson of the relinquished Medical Staff member will reassign care of the member’s patients and on-call obligations as needed.

3. Automatic Relinquishment under this section is not considered a professional review action and will not entitle the Practitioner or AHP concerned to any of the procedural rights with respect to a Medical Staff Hearing or Appeal.

PART E: INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

1. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual or the operations of the Hospitals, the System Chief of Staff, the Hospital Chief of Staff, CEO or designee, or the MEC is authorized to precautionarily suspend or restrict all or any portion of a Practitioner’s Clinical Privileges.

2. Reasons for a precautionary suspension may include, but are not limited to, concerns about: (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff, including failure to fulfill on-call obligations; or (d) conduct that is considered lower than the standards of the Hospital (as reflected in its Code of Conduct) or of the Medical Staff or which is disruptive to the orderly operation of the Hospital or the Medical Staff.

3. A precautionary suspension is effective immediately and will remain in effect unless it is modified by the System Chief of Staff, the Hospital Chief of Staff, the MEC or the CEO.

4. The individual shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction.
5. The MEC will review the reasons for the suspension/restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

PART F: MANDATORY MEETING

The Credentials Committee, MEC, the Medical Staff Officers, or an investigation committee appointed by the MEC or Medical Staff Officers may require a Medical Staff member to attend a Mandatory Meeting. Written notice of the time and place shall be provided to the Medical Staff member at least five (5) days in advance by certified mail, hand delivery or any other delivery method in which confirmation of receipt is obtained. The written notice shall include a statement of the issue involved and that the member’s attendance is mandatory. Failure of a member to attend a mandatory meeting or to respond to the written notice will result in automatic relinquishment of the Medical Staff member’s Clinical Privileges, effective on the scheduled date of the Mandatory Meeting. Thereafter, if the meeting does not occur within seven (7) days after the original scheduled date of the Mandatory Meeting, the member will be considered to have voluntarily resigned his or her Medical Staff membership and Clinical Privileges without right to a Medical Staff Hearing or Appeal. A Mandatory Meeting does not constitute an investigation.
ARTICLE 5

QUALIFICATIONS OF OFFICERS, HOSPITAL CHIEFS AND VICE CHIEFS OF STAFF, DEPARTMENT CHAIRPERSONS AND VICE CHAIRPERSONS, COMMITTEE CHAIRPERSONS AND VICE CHAIRPERSONS, AND MEC COMPOSITION

PART A. REQUIREMENTS FOR ALL OFFICERS, HOSPITAL CHIEFS AND VICE CHIEFS OF STAFF, DEPARTMENT CHAIRPERSONS AND VICE CHAIRPERSONS, AND COMMITTEE CHAIRPERSONS AND VICE CHAIRPERSONS

1. In order to be eligible to serve as a Medical Staff Officer, Hospital Chief or Hospital Vice Chief of Staff, Department Chairperson or Vice Chairperson or Committee Chairperson or Vice Chairperson, a Medical Staff member must:
   a. be appointed to the Active or Senior Staff (unless otherwise provided herein) and continue so during his or her term of office;
   b. use one or more of the Hospitals as his or her primary Hospital and admit a majority of his or her patients requiring hospitalization to the Hospitals or have a majority of his or her patient contacts (as defined within these Bylaws) at the Hospitals;
   c. for Hospital Chief of Staff and Hospital Vice Chief of Staff and Department Chairpersons and Vice Chairpersons, maintain the majority of their patient contacts at the Hospital Facility where they are elected;
   d. not concurrently serve at a non-Orlando Health hospital as Medical Staff Officer or corporate Officer, Chief of Staff and Vice Chief of Staff, Department Chairperson or Vice Chairperson, or Committee Chairperson or Vice Chairperson;
   e. have constructively participated in Medical Staff affairs at the Hospitals, including peer review activities if requested by Medical Staff leadership;
   f. be knowledgeable concerning the duties of the position to which he or she is elected or appointed;
   g. be willing to discharge faithfully the duties and responsibilities of the position to which he or she is elected or appointed, including quality and value based medical care within the Hospitals;
   h. comply with the Orlando Health conflict of interest policy and code of conduct; and
   i. not be under investigation, not have any portion of his or her Clinical Privileges suspended or restricted and not be on leave of absence. Medical Staff members who are subject to a behavioral contract or performance agreement must request and be granted a waiver by the Medical Staff Officers to be eligible.

2. Hospital Chief and Hospital Vice Chief of Staff. A Hospital Chief of Staff and Hospital Vice Chief of Staff are elected at each Hospital Facility. The details of Hospital Chief of Staff and Hospital Vice Chief of Staff elections and functions are as set forth in the Medical Staff Organizational Policy. In the event of a conflict between the Organizational Policy and these Bylaws, the terms of these Bylaws will prevail.
3. All Medical Staff Officers, Hospital Chiefs of Staff and Hospital Vice Chiefs of Staff, Department Chairpersons and Vice Chairpersons and Committee Chairpersons and Vice Chairpersons must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved. The individual shall have the burden of providing adequate documentation to verify that he or she meets the above qualifications, in the event that there are questions about the individual's qualifications.

4. Additional Qualifications for Officers. It is required that, in addition to meeting the above requirements, a member must have previously served at a Hospital for at least one (1) term in one or more of the following positions: Department Chairperson, Vice Chairperson, or section Chief; Hospital Chief of Staff (formerly Chairperson of a Leadership Committee); or a member of the Credentials Committee, or Peer Review Committee; or served in an ongoing leadership role in quality or collaborative practice committee prior to serving as a Medical Staff Officer.

PART B: OFFICERS OF THE MEDICAL STAFF

1. The Officers of the Medical Staff shall be the System Chief of Staff, the System Vice Chief of Staff, and the Immediate Past System Chief of Staff. At the time of nomination and election and at all times during their term of office, Officers must be members of the Active Medical Staff who meet the requirements in Article 5 Part A. Failure to maintain such status shall immediately create a vacancy in the office involved. The Officers of the Medical Staff shall be excused from emergency service call and other service duties during their terms of office.

2. System Chief of Staff. The System Chief of Staff shall:
   a. Act on behalf of the Medical Staff in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the Hospitals;
   b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
   c. Appoint committee chairpersons and members, who shall serve at the request of the Chief of Staff, to all standing, special and multi-disciplinary Medical Staff committees except the MEC and the Hospital Medical Staff Leadership Committees;
   d. In the event of a vacancy, appoint interim Department Chairpersons and Hospital Chiefs of Staff to perform necessary functions while awaiting Board approval of a nominee;
   e. Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer and to the Board;
   f. Be the Chairperson of the MEC.
   g. Serve as ex officio member of all other Medical Staff committees, with vote;
3. System Vice Chief of Staff. The System Vice Chief of Staff shall:
   a. Assume all the duties and have the authority of the System Chief of Staff in the absence of the Chief of Staff;
   b. Be a member of the MEC and serve as Chairperson of the Credentials Committee;
   c. Serve as ex-officio member of all other Medical Staff committees, with vote;
   d. Automatically succeed the System Chief of Staff when the latter fails to serve for any reason;
   e. Perform such duties as are assigned by the System Chief of Staff;
   f. Be the System Chief of Staff-Elect.

4. Immediate Past System Chief of Staff. The Immediate Past System Chief of Staff shall:
   a. Assume all the duties and have the authority of the System Chief of Staff in the absence of both the System Chief of Staff and the System Vice Chief of Staff;
   b. Be a member of the MEC and the Credentials Committee;
   c. Act as Secretary-Treasurer of the Medical Staff; including keeping records of all meetings of the Medical Staff and MEC (or supervising the keeping of such records) and making disbursements from Medical Staff funds (if any) as authorized by the MEC and in accordance with applicable Orlando Health, Hospital, and Medical Staff policies and procedures.

5. Term of Office; Vacancy; Removal
   a. The term of office for Medical Staff Officers shall be two (2) years. The Officers may not hold their offices for more than one (1) consecutive two-year term, except as provided in paragraph (b) below.
   b. If there is a vacancy in the office of System Chief of Staff, the System Vice Chief of Staff shall serve out the remaining term and shall then serve as System Chief of Staff for the term for which elected.
   c. If there is a vacancy in the office of System Vice Chief of Staff, a new System Vice Chief of Staff shall be elected within sixty (60) calendar days. The MEC may appoint an Acting System Vice Chief of Staff pending such election. The election shall be in accordance with the procedures in this Article.
   d. If there is a vacancy in the office of Immediate Past System Chief of Staff, the MEC shall appoint another former System Chief of Staff to serve out the remaining term.
   e. Removal of a Medical Staff Officer may be effectuated by:
      i. a two-thirds (2/3) vote of the members of the MEC, upon approval by the Board; or
ii. a two-thirds (2/3) vote of the Medical Staff members eligible to vote provided that at least twenty-five percent (25%) of the eligible members submit a vote, upon approval by the Medical Staff Executive Committee and the Board; or

iii. the Board.

iv. Grounds for removal shall include, but shall not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the job.

f. Pending formal removal of an Officer, the CEO has the authority to immediately suspend an Officer from performing the duties of his or her office. Removal shall be effective when it has been approved by the Board. Suspension and Removal do not affect Medical Staff membership and Clinical Privileges and do not entitle the individual concerned to any of the procedural rights provided in Article 7 with respect to Medical Staff Hearings and Appeals.


a. Every two (2) years, the Active and Senior Staff members shall elect a System Vice Chief of Staff, who shall become System Chief of Staff at the conclusion of his or her term as System Vice Chief of Staff, and Immediate Past System Chief of Staff at the conclusion of his or her term as System Chief of Staff.

b. The System Vice Chief of Staff shall be elected for a two-year term by a majority vote of Active Staff and Senior Staff voting in the election. The election of the System Vice Chief of Staff will be conducted by written ballot, which may be paper or electronic. The election of the System Vice Chief of Staff shall become effective as soon as approved by the Board. The System Vice Chief of Staff shall then serve until a successor has been elected and the election approved by the Board.

c. The election shall be held every odd year at a time to be determined each election year, which time shall be sufficient to allow the new Officers to take office on July 1 and which time shall be announced sufficiently in advance of the election to permit submission of nominations as provided herein.

d. The System Chief of Staff shall appoint a nominating committee to present one or more candidates for the System Vice Chief of Staff position to the MEC. Nominees, in addition to those presented by the nominating committee, may also be made from the floor. Following approval of the nominees by the MEC, notification of nominees is sent to the Active and Senior Active members of the Medical Staff.

e. Nominations may also be made by Active Staff and Senior Staff provided such nominations are endorsed by legible signatures of at least twenty-five (25) such members. Nominations must be signed by the person(s) making the nominations and by the person nominated signifying his or her acceptance of the nomination. All nominations must be submitted to the Medical Staff Services Office no later than twenty-one (21) calendar days prior to the election.
f. If there are three (3) or more candidates for System Vice Chief of Staff and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.

g. The System Chief of Staff shall designate the place to which ballots are to be returned and the date and time by which completed ballots must be received. Only those ballots received at the designated place on or before the designated time will be counted.

h. If the MEC presents a single nomination for System Vice Chief of Staff and there are no additional nominations, the unopposed candidate shall be deemed to be elected and no election will be held.

**PART C: MEDICAL EXECUTIVE COMMITTEE**

1. The MEC shall consist of the System Chief of Staff, the System Vice Chief of Staff, the immediate past System Chief of Staff, the Hospital Chief of Staff and Hospital Vice Chief of Staff of each Hospital Facility, and representatives from each clinical department as follows:

   a. The Chairperson of each Clinical Department; and

   b. For Clinical Departments with over forty (40) voting members, the Vice Chairperson of the Clinical Department.

2. All members of the Active Staff of any discipline or specialty are eligible for membership on the MEC, subject to the provisions of these Bylaws.

3. The majority of voting MEC members must be fully licensed Doctor of Medicine and osteopathy actively practicing in a Hospital.

4. The System Chief of Staff shall be Chairperson of the MEC.

5. The Chief Executive Officer, the Designated Institutional Officer, Hospital Presidents, Corporate COO, Hospital CQO(s), CMO and members of the Board may attend meetings of the MEC and participate in the discussions, but without vote.

6. Hospital legal counsel shall be invited to attend meetings of the MEC, without vote.

7. The MEC shall have the following duties:

   a. Coordinate the activities and general policies of the various Hospital Facilities.

   b. Receive and act upon reports of Medical Staff committees, departments, and assigned activity groups, and make recommendations concerning them to the CEO and the Board;

   c. Make recommendations directly to the Board regarding Medical Staff structure, the mechanism used to review credentials and to delineate individual Clinical
Privileges, the mechanism by which Medical Staff membership may be terminated, and the mechanism for Medical Staff Hearing procedures.

d. Make recommendations directly to the Board relating to appointments, reappointments, staff category, department assignments, Clinical Privileges, and corrective action;

e. Make recommendations directly to the Board regarding the Orlando Health Performance Improvement Plan, the Clinical Departments’ rules and regulations, and all Clinical Privilege Descriptions.

f. Implement policies of the Medical Staff which are not the responsibility of the departments or Hospital Facilities.

g. Provide a liaison among Medical Staff, the CEO, and the Board;

h. Recommend action to the CEO on matters of a medico-administrative and Hospital management nature;

i. Ensure that the Medical Staff is kept abreast of the Hospital accreditation program and informed of the accreditation status of the Hospital;

j. Take all reasonable steps to ensure professionally ethical conduct and to enforce Hospital and Medical Staff bylaws, rules and regulations and policies and procedures in the best interest of patient care and of the Hospital on the part of all members of the Medical Staff.

k. Refer situations involving questions of the clinical competence, patient care and treatment or patient management of any individual members of the Medical Staff to the Credentials Committee for appropriate investigation and recommendation.

l. Present to the Medical Staff one or more nominees for System Vice Chief of Staff (Chief Elect) during each election year and in the event of a vacancy in the office.

m. Represent and act on behalf of the Medical Staff between meetings of the organized Medical Staff within the scope of its responsibilities and in accordance with the Medical Staff Governing Documents.

n. Make recommendations directly to the Board regarding amendments to Medical Staff Governing Documents.

8. The Chairperson of the MEC, the Chairperson’s representative, and such members of the committee as the Chairperson deems necessary shall be available to meet with the Board, or its applicable subcommittee, on all recommendations that the MEC may make. It is the purpose of these Bylaws to increase direct communication between the Board and the MEC on all matters within the scope of the MEC’s duties.

9. Meetings, Reports and Recommendations. The MEC shall meet at least quarterly, or more often if necessary. The Immediate Past Chief of Staff or designee will maintain a report of each meeting, which shall include the minutes of the MEC and the minutes of the various committees and departments meetings of the Medical Staff. Copies of the MEC
As of (DATE) Medical Staff Bylaws

report shall be transmitted to the Chief Executive Officer and the Clinical Department Chairpersons following each MEC meeting. Recommendations of the MEC shall be transmitted to the Chief Executive Officer and the Board.

10. Officer Subcommittee. Between meetings of the MEC, the Officers of the Medical Staff may form a subcommittee, which shall be empowered to act on behalf of the MEC in situations of urgent and/or confidential concern. Any actions taken by the Officer Subcommittee will be presented to the MEC at its next regularly scheduled meeting for ratification or other action as necessary. An Officer Subcommittee may not make a recommendation to the Board which would constitute grounds for a Medical Staff Hearing pursuant to these Bylaws without first presenting such recommendation to the MEC.

11. Operations Subcommittee. The MEC may form an Operations Subcommittee and delegate to the Operations Subcommittee such functions as it shall deem appropriate; provided, however that the Operations Subcommittee may not make a recommendation to the Board which would constitute grounds for a Medical Staff Hearing pursuant to these Bylaws without first presenting such recommendation to the MEC. The Operations Subcommittee shall consist of the System Chief of Staff, the System Vice Chief of Staff, the System Immediate Past Chief of Staff, and a minimum of four (4) members of the MEC appointed by the Chief of Staff.

PART D: DEPARTMENT CHAIRPERSON, VICE CHAIRPERSON, AND COMMITTEE CHAIRPERSONS

1. Functions of Department Chairpersons. Each Chairperson shall on behalf of the Hospital:

a. Be responsible for the organization of all Medical Staff activities of the Department and for the general administration of the Department, including but not limited to assigning to members of the Department functions and responsibilities including, where appropriate, service patients, emergency service care and consultation, unassigned inpatient consultations, teaching assignments, and participating in peer review activities;

b. Be responsible for setting and managing the Department call schedule. The Department Chairperson will assign call to members of the Department in a fair and equitable manner.

c. Be responsible for the orientation and continuing education of all persons in the Department.

d. Attend mandatory Department Chairperson orientation.

e. Be a member of the Hospital Facility Medical Staff Leadership Committee of the Hospital Facility in which the Department is located and attend at least fifty percent (50%) of the scheduled Hospital Facility Medical Staff Leadership Committee meetings (compliance with this requirement will be measured on a yearly basis from the commencement of their term);

f. Maintain continuing review of the professional performance of all individuals with Clinical Privileges in the Department (including but not limited to participation in Focused Professional Practitioner Evaluation (FPPE) and Ongoing Professional
Practitioner Evaluation (OPPE) and report and recommend thereon to the Credentials Committee when appropriate;

g. Be responsible for enforcement within the Department of the Hospital bylaws, the Medical Staff Bylaws, policies and procedures, the Medical Staff Rules and Regulations, the Department Rules and Regulations;

h. Upon receipt of information about Department members (including but not limited to incident reports, peer reviews, quality outcome data, professional conduct, HCAHPS scores, and medical record compliance reports), counsel Department members and document accordingly;

i. Be responsible for implementation within the Department of actions taken by the Medical Executive Committee and the Hospital Facility Medical Staff Leadership Committee of the Hospital Facility in which the Department is located;

j. Transmit to the Credentials Committee, the recommendations concerning the appointment, reappointment, and delineation of Clinical Privileges, if any, for all individuals in and applicants to the Department;

k. As applicable, be responsible for the establishment, implementation and effectiveness of the teaching, education, and research program in the Department in conjunction with the Graduate Medical Education department;

l. Be responsible for the general administration of the Department, reporting and recommending through the Hospital Facility Medical Staff Leadership Committee of the Hospital Facility in which the Department is located to Hospital management, when necessary, with respect to matters affecting patient care, including space, personnel, supplies, special regulations, standing orders and techniques;

m. Assessing and recommending to Hospital management off-site sources for needed patient care services not provided by the Department or Orlando Health;

n. Assist the Hospital management in the preparation of annual reports and such budget planning pertaining to the Department;

o. Assign such duties to the Vice Chairperson of the Department as he or she shall deem appropriate;

p. Recommends establishment of sections within the Department and appoint and remove Section Chiefs thereof, subject to the approval of the Medical Executive Committee and the Board;

q. In conjunction with members of the Department, recommend to the Medical Staff the criteria for Clinical Privileges in the Department;

r. Be responsible for all clinically related activities of the Department;

s. Be responsible for integration of the Department into the primary functions of the Hospital and coordination and integration of interdepartmental and intradepartmental services;
t. Assist in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

u. Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

v. Determine and recommend the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

w. Be responsible for the continuous assessment and improvement of the quality of care, treatment, and services;

x. Be responsible for the maintenance of quality control programs, as appropriate (including but not limited to the development and oversight of quality metrics);

y. Be responsible for maintaining confidentiality of information identified as confidential; and

z. Perform such other duties as are assigned by the System or Hospital Chief of Staff, Vice Chief of Staff, or the Board, or as provided by contract.

2. Functions of Department Vice Chairpersons. Each Vice Chairperson shall on behalf of the Hospital:

a. Be a member of the Hospital Facility Medical Staff Leadership Committee of the Hospital Facility in which the Department is located and attend at least fifty percent (50%) of the scheduled Hospital Facility Medical Staff Leadership Committee meetings (compliance with this requirement will be measured on a yearly basis from the commencement of their term);

b. Assist the Department Chairperson with continuing review of the professional performance of all individuals with Clinical Privileges in the Department (including but not limited to participation in FPPE/OPPE) and report and recommend thereon to the Credentials Committee when appropriate;

c. Attend mandatory Chairperson orientation.

d. Participate in the maintenance of quality control programs, as appropriate (including but not limited to the development and oversight of quality metrics);

e. Assume all the duties and have the authority of the Department Chairperson in the absence of the Department Chairperson when delegated by the System or Hospital Chief of Staff when necessary for reasons such as conflict of interest or temporary incapacity of the Department Chairperson;

f. Be responsible for maintaining confidentiality of information identified as confidential; and

g. Perform such other duties as are assigned by the Department Chairperson, System
3. The details of Department Chairperson and Vice Chairperson elections are as set forth in the Medical Staff Organizational Policy. In the event of a conflict between the Organizational Policy and these Bylaws, the terms of these Bylaws will prevail.

4. The details of Committee Chairpersons and Vice Chairpersons appointment and functions are as set forth in the Medical Staff Organizational Policy. In the event of a conflict between the Organizational Policy and these Bylaws, the terms of these Bylaws will prevail.
ARTICLE 6

MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS

1. A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

2. For a medical History and Physical examination that was completed within thirty (30) calendar days prior to registration or inpatient admission, there must be an updated medical record entry documenting an examination for any changes in the patient’s condition (e.g., “History and Physical reviewed, patient examined, no changes” or outline changes that occurred). This updated examination must be completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

3. Only those granted privileges to do so may conduct and update medical History and Physical examinations, except as provided in section 4 below. Privileges to conduct and update medical histories and physical examinations are granted to:
   a. Physicians
   b. Oral surgeons, for those patients admitted solely for oral and maxillofacial surgery.
   c. Dentists, but only for that part of the History and Physical examination related to dentistry.
   d. Podiatrists, but only for that part of the History and Physical examination related to podiatry.
   e. Other qualified individuals who are not licensed independent practitioners may be allowed pursuant to their scope of practice to perform part or all of patients’ medical histories and physical examinations under the supervision of, or through appropriate delegation by, a physician who is a Medical Staff member with appropriate Clinical Privileges who is accountable for the patient’s History and Physical examination. These medical History and Physical examinations must be validated and countersigned by a licensed independent practitioner with appropriate Clinical Privileges within 24 hours.

4. A medical History and Physical examination conducted by a practitioner who is permitted by law to perform it but who is not credentialed and privileged by the Hospitals may be used provided that a Practitioner who is credentialed and privileged by the Hospitals:
   a. Reviews the History and Physical examination documentation;
   b. Determines if the information is compliant with Orlando Health’s required minimal content and was completed within the required timeframe;
   c. Obtains any missing information through further assessment;
d. Updates information and findings as necessary, which may include, but is not limited to,

i. Inclusion of absent or incomplete required information.

ii. A description of the patient’s condition and course of care since the History and Physical was performed.

iii. A signature, dictation number, date, and time on any document with updated or revised information as an attestation that it is current.

e. Documents in the medical record that they have reviewed the medical History and Physical.

5. Medical histories and physical examinations must comply with additional requirements as set forth in the Medical Staff Rules and Regulations.
ARTICLE 7

MEDICAL STAFF HEARINGS AND APPEALS

PART A: INITIATION OF HEARING

1. Grounds for Hearing. Only the following actions constitute grounds for a Medical Staff Hearing:
   
   a. Denial of initial appointment;
   
   b. Denial of reappointment;
   
   c. Denial of reinstatement from leave of absence
   
   d. Revocation of appointment;
   
   e. Denial of requested initial Clinical Privileges;
   
   f. Denial of requested increased Clinical Privileges;
   
   g. Reduction of Clinical Privileges;
   
   h. Revocation of Clinical Privileges;
   
   i. Imposition of a mandatory concurring consultation requirement; or
   
   j. Suspension of Clinical Privileges for more than thirty (30) calendar days.

2. Actions Not Grounds for Hearing. None of the following actions constitute grounds for a Medical Staff Hearing. These actions take effect without Medical Staff Hearing or Appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her credentialing file:
   
   a. A letter of guidance, counsel, warning, or reprimand;
   
   b. Conditions, monitoring, proctoring, or a general consultation requirement;
   
   c. A lapse, withdrawal of or decision not to grant or not to renew temporary privileges;
   
   d. Automatic relinquishment of appointment or privileges;
   
   e. A requirement for additional training or continuing education;
   
   f. Precautionary suspension less than thirty (30) days;
   
   g. Denial of a request for leave of absence or for an extension of a leave;
h. Removal from the on-call roster or any other reading panel;

i. The voluntary acceptance of a performance improvement plan option;

j. Determination that an application is incomplete;

k. Determination that an application will not be processed due to a misstatement or omission; or

l. Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

3. Notice of Recommendation. When a recommendation is made that, according to these Bylaws, entitles an individual to a formal Medical Staff Hearing prior to a final decision of the Board on that recommendation, the applicant, or Medical Staff member, as the case may be, shall promptly be given notice. This notice will contain:

   a. A statement of the recommendation and the general reasons for it;

   b. A statement that the individual has the right to request a Medical Staff Hearing on the recommendation within thirty (30) days of receipt of this notice; and

   c. A copy of this Article.

4. Hearing Request. An individual has thirty (30) days following receipt of the Notice of Recommendation to request a Medical Staff Hearing, in writing, to the CEO, including the name, address, and telephone number of the individual’s counsel, if any. Failure to timely request a Medical Staff Hearing will constitute the individual’s waiver of the right to a Medical Staff Hearing, and the recommendation will be transmitted to the Board for final action.

5. Notice of Hearing and Statement of Reasons. The System Chief of Staff will schedule the Medical Staff Hearing and provide to the individual requesting the Medical Staff Hearing a Notice stating:

   a. The time, place, and date of the Medical Staff Hearing;

   b. A list of witnesses, if known, who will give testimony at the Medical Staff Hearing and a brief summary of the anticipated testimony;

   c. The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

   d. A statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and/or the other information supporting the recommendation. This statement may be revised or amended at any time, even during the Medical Staff Hearing, so long as the additional material is relevant to the recommendation or the individual’s qualifications and the individual has had a
sufficient opportunity, up to thirty (30) days, to review and respond with additional information.

6. The Medical Staff Hearing will be scheduled to begin as soon as practicable, but no sooner than thirty (30) days after the notice of the Medical Staff Hearing, unless an earlier Medical Staff Hearing date has been specifically agreed to in writing by the parties.

7. Hearing Panel. The System Chief of Staff, in consultation with the CEO, will appoint a Hearing Panel of at least three members, one of whom will be designated as chairperson.

a. The Hearing Panel may include any combination of any member of the Medical Staff or Allied Health Staff; or physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Allied Health Staff or laypersons not affiliated with the Hospital).

b. Knowledge of the underlying matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

c. Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

d. The Hearing Panel will not include any individual who is in direct economic competition with the individual requesting the Medical Staff Hearing, is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the Medical Staff Hearing, has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter, or actively participated in the matter at any previous level.

8. Hearing Officer.

a. As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies (not issues of clinical competence, knowledge, or technical skill), the CEO, after consulting with and obtaining the agreement of the System Chief of Staff, may appoint a Hearing Officer in lieu of a Hearing Panel and Presiding Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing panel and the Presiding Officer. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

b. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” will be deemed to refer to the Hearing Officer.

9. Presiding Officer. The CEO, after consultation with the System Chief of Staff, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the Medical Staff Hearing. The Presiding Officer will be compensated by the Hospital and the individual who requested the Medical Staff Hearing may participate in that compensation. The Presiding Officer will:
a. Schedule and conduct a pre-hearing conference and allow the participants in the Medical Staff Hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive or that causes undue delay;

c. Maintain decorum throughout the Medical Staff Hearing;

d. Determine the order of procedure;

e. Rule on matters of procedure and the admissibility of evidence; and

f. Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

g. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the Medical Staff Hearing procedure.

h. The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel’s decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

10. Objections. Any objection to any member of the Hearing Panel, or to the Hearing or Presiding Officer, will be made in writing, within ten (10) days of receipt of notice, to the CEO. The objection must include reasons to support it. A copy of the objection will be provided to the System Chief of Staff. The System Chief of Staff will be given a reasonable opportunity to comment. The CEO will rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

11. Counsel. The Presiding Officer and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

PART B: PRE-HEARING PROCEDURES

1. General Procedures. The pre-hearing and Medical Staff Hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

2. Time Frames. The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

a. The pre-hearing conference will be scheduled at least fourteen (14) days prior to the Medical Staff Hearing;

b. The parties will exchange witness lists and proposed documentary exhibit lists at least fifteen (15) days prior to the pre-hearing conference;
c. Each party will provide the other party with its proposed exhibits ten (10) days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon mutually by both sides; and

d. Any objections to witnesses and/or proposed documentary exhibits must be provided at least five (5) days prior to the pre-hearing conference.

3. Provision of Relevant Information. Prior to receiving any confidential documents, the individual requesting the Medical Staff Hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the Medical Staff Hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided. Upon receipt of the above agreement and representation, the individual requesting the Medical Staff Hearing will be provided with a copy of the following:

a. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual’s expense;

b. reports of experts relied upon by the Medical Staff Executive Committee;

c. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

d. copies of any other documents relied upon by the Medical Staff Executive Committee.

e. The provision of this information is not intended to waive any privilege.

f. The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners on the Medical Staff or Allied Health Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the Medical Staff Hearing.

g. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Staff members whose names appear on the Medical Staff Executive Committee’s witness list or in documents provided pursuant to this section concerning the subject matter of the Medical Staff Hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the Medical Staff Hearing once it has contacted such employees, Medical Staff members or Allied Health Staff members, and confirmed their willingness to meet. Any employee, Medical Staff or Allied Health Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a Medical Staff Hearing.

4. Pre-Hearing Conference. The Presiding Officer will require the individual and the MEC (or a representative of each, who may be counsel) to participate in a pre-hearing conference.
a. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

b. Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant Clinical Privileges will be excluded.

c. The Presiding Officer will establish the time to be allotted to each witness’s testimony and cross-examination.

5. Stipulations. The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient Medical Staff Hearing.

6. Provision of Information to the Hearing Panel. In advance of the Medical Staff Hearing, the Hearing Panel will be provided a pre-hearing statement that either party may choose to submit, exhibits offered by the parties following the pre-hearing conference (without the need for authentication), and stipulations agreed to by the parties.

**PART C: THE HEARING**

1. Time Allotted for Hearing. It is expected that the Medical Staff Hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a Medical Staff Hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

2. Record of Hearing. A stenographic reporter will be present to make a record of the Medical Staff Hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual’s expense. Oral evidence will be taken on oath or affirmation administered by any authorized person.

3. Rights of Both Sides and the Hearing Panel at the Hearing. At a Medical Staff Hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

   a. To call and examine witnesses, to the extent they are available and willing to testify;

   b. To introduce exhibits;

   c. To cross-examine any witness;

   d. To have representation by counsel;

   e. To submit a written statement at the close of the Medical Staff Hearing; and

   f. To submit proposed findings, conclusions, and recommendations to the Hearing Panel.
g. If the individual who requested the Medical Staff Hearing does not testify, he or she may be called and questioned.

h. The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

4. Order of Presentation. The MEC will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the Medical Staff Hearing to present evidence.

5. Admissibility of Evidence. The Medical Staff Hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs. The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this state. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of hearing. The person requesting the hearing shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and Clinical Privileges.

6. Persons to Be Present. The Medical Staff Hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the System Chief of Staff.

7. Presence of Hearing Panel Members. A majority of the Hearing Panel will be present throughout the Medical Staff Hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the Medical Staff Hearing, he or she will read the entire transcript of the portion of the Medical Staff Hearing from which he or she was absent.

8. Failure to Appear. Failure of the individual who requested the hearing, without good cause, to appear and proceed at the Medical Staff Hearing will constitute a waiver of the right to a Medical Staff Hearing and the matter will be forwarded to the Board for final action.

9. Postponements and Extensions. Postponements and extensions of time may be requested by anyone but will be permitted only by the Presiding Officer or the CEO on a showing of good cause.

PART D: THE HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

1. Basis of Hearing Panel Recommendation and Burden of Proof. Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and Clinical Privileges, the Hearing Panel
will recommend in favor of the MEC unless it finds that the individual who requested the Medical Staff Hearing has proved, by clear and convincing evidence, that the recommendation that prompted the Medical Staff Hearing was arbitrary, capricious, or not supported by credible evidence.

2. Deliberations and Recommendation of the Hearing Panel. Within twenty (20) days after final adjournment of the Medical Staff Hearing (which may be designated as the time the Hearing Panel receives the Medical Staff Hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

3. Disposition of Hearing Panel Report. The Hearing Panel will deliver its report to the CEO. The CEO will send by a copy of the report to the individual who requested the Medical Staff Hearing. The CEO will also provide a copy of the report to the System Chief of Staff.

PART E: APPEAL PROCEDURE

1. Time for Appeal. Within ten (10) days after notice of the Hearing Panel’s recommendation, either party may request an Appeal. The request will be in writing, delivered to the CEO in person or by certified mail, return receipt requested, and will include a statement of the reasons for Appeal and the specific facts or circumstances which justify further review. If an Appeal is not requested within ten (10) days, an Appeal is deemed to be waived and the Hearing Panel’s report and recommendation will be forwarded to the Board for final action.

2. Grounds for Appeal. The grounds for Appeal will be limited to the following:
   a. There was substantial failure by the Hearing Panel to comply with the Medical Staff Bylaws during the Medical Staff Hearing, so as to deny a Medical Staff Hearing; or
   b. The recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

3. Time, Place and Notice. Whenever an Appeal is requested, the chair of the Board will schedule and arrange for an Appeal. The individual will be given notice of the time, place, and date of the Appeal. The Appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

   a. The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board, or others, including but not limited to persons outside the Hospital.
   b. The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the MEC and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.
c. Each party will have the right to present a written statement in support of its position on Appeal. The party requesting the Appeal will submit a statement first and the other party will then have ten (10) days to respond. In its sole discretion, the Review Panel may allow each party, or its representative, to appear personally and make oral argument not to exceed thirty (30) minutes.

d. When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the Medical Staff Hearing was improperly denied.

**PART F: BOARD ACTION**

1. Final Decision of the Board. The Board will take final action within thirty (30) days after it: (i) considers the Appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no Appeal has been requested. If the Board is not able to make its final recommendation within thirty (30) days, it will notify the Practitioner involved of the delay.

2. The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Staff Executive Committee, Hearing Panel, and Review Panel (if applicable).

3. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

4. The Board will render its final decision in writing and will send notice to the individual. A copy will also be provided to the System Chief of Staff.

5. Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

6. Right to One Hearing and One Appeal Only. No individual will be entitled to more than one Medical Staff Hearing and one Appeal on any matter.
ARTICLE 8

CONFLICT OF INTEREST

PART A: MEMBER PARTICIPATING IN CREDENTIALING, PEER REVIEW AND MEDICAL STAFF FUNCTIONS

1. In any instance where an Officer, or Clinical Department or Medical Staff Committee Chairperson, or member of any Medical Staff Committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff applicant or member that comes before such individual or Medical Staff Committee, such individual or member may be asked by the applicable Chairperson to refrain from participation in the discussion or voting on the matter, and may be excused from any meeting during that time, although that individual or Medical Staff Committee member may be asked, and may answer, any questions concerning the matter before leaving.

2. A Clinical Department Chairperson shall have a duty to delegate review of applications for appointment, reappointment or Clinical Privileges, or questions that may arise to a Vice Chairperson or other member of the Clinical Department, if the Chairperson has a conflict of interest with the individual under review or could be reasonably perceived to be biased.

3. In appointing members of the Medical Staff to an Investigation Committee, Hearing Panel or other Ad Hoc Committee formed for the purpose of reviewing a particular member or applicant, the individual or body making the appointment shall ask potential appointees to disclose conflicts of interest (potential and/or actual) which shall be considered in making the appointment. Conflicts of Interest shall be avoided whenever possible.

4. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the System Chief of Staff (or the System Vice Chief of Staff if the System Chief of Staff is the person with the potential conflict) or the applicable Clinical Department or Medical Staff Committee chair. The System Chief of Staff or the applicable Clinical Department or Medical Staff Committee chair will make a final determination as to whether the provisions in this Article should be triggered.

5. The fact that a Clinical Department Chairperson or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

PART B: ORLANDO HEALTH CONFLICT OF INTEREST POLICY #5706-0329

1. Medical Staff members are also subject to and bound by the Orlando Health Conflict of Interest Policy #5706-0329.
ARTICLE 9
MEDICAL STAFF RULES & REGULATIONS AND POLICIES

1. The MEC, with the approval of the Board, shall adopt Rules and Regulations, credentialing policies, an Organizational Policy, and other Medical Staff policies as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. These Rules and Regulations and Medical Staff policies shall set standards of practice that are to be required of each Medical Staff member in the Hospitals and shall act as an aid to evaluating performance under, and compliance with, these standards. These Rules and Regulations and Medical Staff policies shall have the same force and effect as the Bylaws.

2. Procedures for Adoption and Amendment of the Rules and Regulations and Medical Staff policies.

a. Adoption and Amendment of the Rules and Regulations may be recommended to the Board by the Medical Executive Committee after a majority vote, provided that the proposed adoption or amendment of any Rule or Regulation shall first be distributed to the members of the Medical Staff for review and comment.

i. Proposals and proposed amendments by the Medical Executive Committee will be distributed to the members of the Medical Staff by mail, facsimile transmission, email, or posting on the Medical Staff pages of the Hospital website at least fourteen (14) days prior to the Medical Executive Committee vote, together with instructions on how interested members may communicate comments to the Medical Executive Committee.

ii. All comments shall be summarized and provided to the Medical Executive Committee prior to its vote.

b. Medical Staff policies may be recommended to the Board by the Medical Executive Committee after a majority vote. No prior notice to the voting members of the Medical Staff is required.

c. Adoption and Amendment of the Rules and Regulations and Medical Staff policies may be proposed by the Medical Staff to the Board by a petition signed by at least twenty (20%) percent of voting members of the Medical Staff, and subsequent majority vote of Active Staff and Senior Staff members who vote.

i. Before any such proposal or amendment is voted on by the Active Staff and Senior Staff members, it shall first be submitted to the Medical Executive Committee at the next meeting of the Medical Executive Committee for review and comment.

ii. The Medical Executive Committee’s recommendation with respect to the proposed rule and regulation or amendment shall accompany the ballot, which may be paper or electronic.

d. In the event of a conflict between the Medical Executive Committee and the voting Medical Staff members regarding the adoption or amendment of any rule and
regulation or Medical Staff policy, the matter may be submitted to the conflict management process in Article 10 of these Bylaws.

3. Procedure for Urgent Amendment of Rules and Regulations. In the event of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with a federal, state, or local law or regulation, the MEC is authorized to provisionally adopt, and the Board provisionally approve without prior notification of the Medical Staff. In this event, the Medical Staff shall immediately be notified of the provisionally adopted and approved amendment and shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the MEC and the voting members of the Medical Staff, the amendment stands. If there is conflict over the provisional amendment, as indicated by a petition signed by at least twenty (20) percent voting members of the Medical Staff, the Conflict Management Process in Article X shall be implemented.

4. Technical Amendments. The MEC shall have the power to adopt technical amendments to the Rules and Regulations without following the process outlined within this Article. Technical amendments are amendments that, in the Committee’s judgment, are technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression.

5. Notification Regarding Rules and Regulations, a Medical Staff credentialing policy, Organizational Policy and other Medical Staff Policies. Notification of adoption of, or amendments to, these documents shall be distributed to the Medical Staff.
ARTICLE 10
CONFLICT MANAGEMENT PROCESS

1. In the event of a conflict between the MEC and the Medical Staff regarding the adoption or amendment of any Rule and Regulation or any Policy and Procedure, upon a petition signed by fifty (50) Active Staff and Senior Staff members of the Medical Staff, the matter shall be submitted to the following conflict resolution process.

2. A Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of Active Staff and Senior Staff members of the Medical Staff designated by the members of the Medical Staff submitting the petition, and an equal number of representatives of the MEC appointed by the System Chief of Staff or designee. The CEO, or designee, shall be an ex-officio non-voting member of the Conflict Resolution Committee.

3. The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties.

4. Any recommendation which is approved by a majority of the petitioners’ representatives and a majority of the representatives of the MEC shall be submitted to the Board for consideration and is subject to final approval by the Board. If agreement cannot be reached by a majority of the petitioners’ representatives and a majority of the representatives of the MEC, the members of the Conflict Resolution Committee shall report to the Board regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute.

5. If deemed appropriate by the System Chief of Staff and the CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

6. This process is intended to be a mechanism for internal, intra-professional resolution of conflicts; therefore, neither party shall be represented by an attorney in this process.

7. The conflict management section is limited to the matters noted above. It shall not be used to address other issues, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

8. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy, or amendment, adopted by the Active Staff and Senior Staff members of the Medical Staff or the MEC in accordance with any mechanism established by the Board for such communications.
ARTICLE 11

AMENDMENTS TO THE BYLAWS

1. Bylaws Committee Procedure. All proposed amendments of these Bylaws whether initiated by the MEC, another Medical Staff Committee, or by a member of the Medical Staff shall be referred to the Bylaws Committee, which shall review and then refer such proposed amendments to the MEC with a recommendation to either accept or reject such amendment.

2. MEC Procedure. All proposed amendments approved by the MEC shall be submitted to Active Staff and Senior Staff members of the Medical Staff for approval in accordance with the procedure in section 4 below. If the MEC does not approve a proposed amendment, it shall notify the Medical Staff Committee or individual that proposed the amendment.

3. Petition. If the MEC does not approve a proposed amendment, any Active Staff or Senior Staff Medical Staff member may cause the proposed amendment to be presented to the Active Staff and Senior Staff Medical Staff members for a vote by obtaining the signatures of fifty (50) members of the Active Staff and Senior Staff Medical Staff members on a petition and submitting the petition to the MEC. Upon receipt of a petition, the MEC shall direct that the proposed amendment be presented to the Active Staff and Senior Staff Medical Staff members for vote in accordance with the procedure in Section 4 below.

4. Procedure for Vote. Proposed amendments may be submitted to the Active Staff and Senior Staff members of the Medical Staff for vote by paper or electronic ballot according to such procedures as are approved by the MEC. The Bylaw Committee’s and MEC’s recommendations with respect to the proposed amendment shall accompany the ballot. Proposed amendments may also be voted on at any meeting of the Medical Staff where all voting members of the Medical Staff are notified and invited to attend, provided that the proposed amendment has been distributed to the voting members of the Medical Staff at least fourteen (14) calendar days in advance of such meeting by mail, facsimile transmission, email, or posting on the Medical Staff pages of the Orlando Health website. To be adopted, an amendment shall require a majority vote of the Active Staff and Senior Staff members voting.

5. Technical Amendments. The MEC shall have the power to adopt such amendments to the Bylaws as are, in the Committee’s judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression.

6. Board Approval. Amendments shall be effective when approved by the Board.

7. Regular Review. The Bylaws Committee shall review these Bylaws at least every two (2) years.
ARTICLE 12

UNIFIED MEDICAL STAFF PROVISIONS

1. Adoption of a Unified Medical Staff. A multi-hospital system may have a unified, systemwide Medical Staff rather than a Medical Staff at each hospital.

   a. If the Board elects to adopt a single unified Medical Staff, then the Medical Staff of each affected separately certified hospital must vote, in accordance with these Bylaws, either to accept a unified and integrated Medical Staff structure or to opt out of such a structure and to maintain a separate and distinct Medical Staff for their respective hospital. Only individuals holding Clinical Privileges may vote to accept or opt out of a unified Medical Staff.

2. Bylaws, Policies, and Rules and Regulations of the Unified Medical Staff. If a unified Medical Staff is approved, then the Unified Medical Staff shall adopt Bylaws, Governing Documents, and Policies and Procedures to:

   a. Take into account the unique circumstances of each separately certified hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

   b. Address the localized needs and concerns of Medical Staff members at each separately certified hospital.

3. Notification of Right to Vote to Opt Out.

   a. If a unified Medical Staff is approved, all Medical Staff members will be notified that members holding privileges to practice at each separately certified Hospital have the right to vote on whether to opt out of the unified Medical Staff structure, and that if a majority vote to opt out, that separately certified hospital must establish a separate Medical Staff.

   b. If a unified Medical Staff is approved, this notification will be provided to all Medical Staff members in writing at initial appointment and at each reappointment at a minimum and may be provided at other times.