

MEDICAL STAFF BYLAWS RULES & REGULATIONS

**UAMS MEDICAL CENTER
LITTLE ROCK, ARKANSAS**

Amended September 2016

TABLE OF CONTENTS

<u>PREAMBLE</u>	2
<u>DEFINITIONS</u>	3
<u>ARTICLE I: NAME</u>	6
<u>ARTICLE II: PURPOSE</u>	6
<u>ARTICLE III: CONDUCT OF MEETINGS</u>	6
3.1 <u>QUORUM AND VOTE</u>	6
3.2 <u>ASSIGNMENT OF RIGHT TO VOTE</u>	6
3.3 <u>RULES</u>	7
<u>ARTICLE IV: SERVICE LINES</u>	7
4.1 <u>SERVICE LINE ORGANIZATION</u>	7
4.2 <u>SERVICE LINE FUNCTIONS</u>	7
4.3 <u>DUTIES OF SERVICE LINE MEMBERS</u>	7
4.4 <u>SERVICE LINE DIRECTOR QUALIFICATIONS</u>	7
4.5 <u>DUTIES OF SERVICE LINE DIRECTOR</u>	8
<u>ARTICLE V: MEDICAL BOARD AND EXECUTIVE COMMITTEE</u>	9
5.1 <u>ORGANIZATION</u>	9
5.2 <u>PURPOSE OF MEDICAL BOARD</u>	9
5.3 <u>COMPOSITION OF MEDICAL BOARD</u>	10
5.4 <u>VACANCIES</u>	10
5.5 <u>DUTIES</u>	10
5.6 <u>TERM OF OFFICE OF MEMBERS OF MEDICAL BOARD</u>	11
5.7 <u>COMPOSITION OF EXECUTIVE COMMITTEE</u>	11
5.8 <u>DUTIES OF EXECUTIVE COMMITTEE</u>	12
5.9 <u>MEETINGS OF MEDICAL BOARD AND EXECUTIVE COMMITTEE</u>	12
<u>ARTICLE VI: ELECTION OF OFFICERS</u>	12
6.1 <u>OFFICERS QUALIFICATIONS</u>	12
6.2 <u>TERM OF OFFICE OF OFFICERS</u>	12
6.3 <u>METHOD OF ELECTION</u>	12
6.4 <u>VACANCIES</u>	13
6.5 <u>REMOVAL FROM OFFICE</u>	13
<u>ARTICLE VII: DUTIES OF OFFICERS, ICE CLINICAL OFFICERS AND UNIT DIRECTORS</u>	14
7.1 <u>CHIEF OF STAFF</u>	14
7.2 <u>CHIEF OF STAFF-ELECT</u>	14
7.3 <u>ICE CLINICAL OFFICERS: QUALIFICATIONS AND APPOINTMENT</u>	14
7.4 <u>ICE CLINICAL OFFICERS: DUTIES</u>	15

7.5	<u>SERVICE LINE LEADERSHIP AND CLINIC PRACTICE DIRECTORS</u>	18
	<u>ARTICLE VIII: MEDICAL BOARD COUNCILS AND COMMITTEES</u>	19
8.1	<u>COUNCILS AND COMMITTEES</u>	19
8.2	<u>APPOINTMENT OF COUNCIL AND COMMITTEE MEMBERS</u>	19
8.3	<u>TERM AND REMOVAL</u>	19
8.4	<u>VACANCIES</u>	20
8.5	<u>DUTIES OF MEMBERS</u>	20
8.6	<u>CHAIR</u>	20
8.7	<u>DUTIES OF THE CHAIR</u>	20
8.10	<u>REPORTING</u>	20
	<u>ARTICLE IX: THE CREDENTIALS COMMITTEE</u>	21
9.1	<u>ORGANIZATION AND PURPOSE</u>	21
9.2	<u>COMPOSITION OF CREDENTIALS COMMITTEE</u>	21
9.3	<u>COMMITTEE RESPONSIBILITIES</u>	21
9.4	<u>MEETINGS OF CREDENTIALS COMMITTEE</u>	21
	<u>ARTICLE X: MEDICAL STAFF RESPONSIBILITIES AND CATEGORIES</u>	22
10.1	<u>GENERAL</u>	22
10.2	<u>RESPONSIBILITIES OF APPOINTMENT</u>	22
10.3	<u>CATEGORIES</u>	24
10.4	<u>ACTIVE MEDICAL STAFF</u>	24
10.5	<u>COURTESY MEDICAL STAFF</u>	24
10.6	<u>HONORARY MEDICAL STAFF</u>	25
10.7	<u>ADVANCED PRACTICE STAFF</u>	25
	<u>ARTICLE XI: MEDICAL STAFF APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES APPLICATION</u>	26
11.1	<u>GENERAL</u>	26
11.2	<u>ELIGIBILITY</u>	26
11.3	<u>APPLICATION REQUIREMENTS</u>	27
11.4	<u>SUBMISSION OF APPLICATION</u>	28
11.5	<u>REVIEW PROCESS</u>	28
11.6	<u>ELEMENTS CONSIDERED IN APPLICATION</u>	30
11.7	<u>INITIAL APPOINTMENT/SIX (6) MONTH REVIEWS</u>	32
11.8	<u>REAPPOINTMENT</u>	32
11.9	<u>CLINICAL PRIVILEGES</u>	35
11.10	<u>TEMPORARY PRIVILEGES</u>	36
11.11	<u>LEAVE OF ABSENCE</u>	37
11.12	<u>CHANGE IN PRIVILEGES</u>	38
11.13	<u>DISASTER PRIVILEGES</u>	38

<u>ARTICLE XII: AUTOMATIC TERMINATION AND SUSPENSION</u>	39
12.1 <u>AUTOMATIC TERMINATION</u>	39
12.2 <u>AUTOMATIC ADMINISTRATIVE SUSPENSION</u>	40
12.3 <u>SUMMARY SUSPENSION</u>	41
12.4 <u>PATIENT REASSIGNMENT</u>	41
<u>ARTICLE XIII: PROFESSIONAL CORRECTIVE ACTION</u>	41
13.1 <u>BASIS FOR PROFESSIONAL REVIEW ACTION</u>	41
13.2 <u>EXAMPLES OF PROFESSIONAL REVIEW ACTION</u>	42
13.3 <u>INVESTIGATIONS</u>	43
13.4 <u>PROFESSIONAL REVIEW ACTIONS</u>	44
<u>ARTICLE XIV: HEARING AND APPEAL</u>	44
14.1 <u> GROUNDS FOR HEARING</u>	44
14.2 <u>REQUEST FOR HEARING</u>	44
14.3 <u>CONDUCT FOR HEARING</u>	45
14.4 <u>ACTION OF HEARING COMMITTEE</u>	46
14.5 <u>APPEAL OF PROFESSIONAL REVIEW ACTION</u>	46
<u>ARTICLE XV: HOUSESTAFF</u>	47
<u>ARTICLE XVI: MEDICAL STAFF MEETINGS</u>	48
<u>ARTICLE XVII: AFFILIATED HEALTH PROFESSIONAL STAFF</u>	48
17.1 <u>GENERAL</u>	48
17.2 <u>CATEGORIES</u>	49
17.3 <u>APPOINTMENT PROCESS</u>	50
17.4 <u>INITIAL APPOINTMENT/SIX (6) MONTH REVIEWS</u>	51
17.5 <u>REAPPOINTMENT</u>	51
17.6 <u>TEMPORARY AUTHORIZATION TO PROVIDE CARE</u>	52
17.7 <u>SUSPENSION AND TERMINATION OF AUTHORIZATION TO PROVIDE CARE</u>	52
<u>ARTICLE XVIII: RULES AND REGULATIONS</u>	53
<u>ARTICLE XIX: ADOPTION OF BYLAWS</u>	53
<u>ARTICLE XX: AMENDMENTS TO BYLAWS</u>	53
<u>ARTICLE XXI: GOVERNING LAW</u>	55
<u>ARTICLE XXII: PRIVILEGES AND IMMUNITIES</u>	55
<u>ARTICLE XXIII: BOARD OF TRUSTEES ACTIONS</u>	55

<u>RULES AND REGULATIONS</u>	56
1. <u>APPLICABILITY</u>	56
2. <u>PROVISION OF PATIENT CARE</u>	56
3. <u>MEDICAL STAFF HOSPITAL POLICIES</u>	56
4. <u>HOUSESTAFF</u>	56
5. <u>CONTINUING EDUCATION</u>	57
6. <u>PROFESSIONAL CONDUCT</u>	57
7. <u>RESEARCH</u>	57
8. <u>REPORTING REQUIREMENTS</u>	57

PREAMBLE

The University of Arkansas for Medical Sciences (UAMS) Medical Center operates under State and Federal laws and regulations to achieve a defined mission of providing patient-centered, cost effective care through a health care system enriched by and committed to education and research.

The Medical Staff of UAMS Medical Center recognizes and accepts the delegated responsibility to promote this mission. Execution of this responsibility entails cooperation with the CEO and accountability to the Medical Board and to the University Of Arkansas Board Of Trustees, the governing body. Therefore, the Medical Staff has resolved to adopt and conform to these Bylaws.¹

¹ MS.01.01.01 EP1

DEFINITIONS

The following definitions apply to these Bylaws:

1. **"Admission"** means placement into an inpatient or observation bed status by a credentialed and privileged physician (admitting physician).
2. **"Advanced Practice Registered Nurse"** shall have the same meaning as this term is defined in the Arkansas Nurse Practice Act.
3. **"Adversely Affect"** means to reduce, restrict, suspend, revoke or deny clinical privileges or Medical Staff membership.
4. **"Appointees"** mean all individuals appointed pursuant to these Bylaws to attend patients of UAMS Medical Center. The term appointee includes Medical Staff, Housestaff and Affiliated Health Staff.
5. **"Board of Trustees"** means the Board of Trustees of the University of Arkansas.
6. **"Chancellor"** means the Chancellor of the University of Arkansas for Medical Sciences.
7. **"Chief Clinical Officer"** means the individual responsible for the professional activities of UAMS Medical Center.
8. **"Chief Executive Officer (CEO)"** means the individual appointed by the Chancellor to act on the Chancellor's behalf in the overall management of UAMS Medical Center.
9. **"Chief of Staff"** means the individual elected by the Medical Board to act, along with the Chief Clinical Officer, as the Medical Staff's chief administrative officers.
10. **"Clinical Privileges"** means the permission granted to an appointee to render specific diagnostic and therapeutic services."
11. **"Clinical Service"** means a clinical program, division, department or service line. These may change from time to time as approved by the Hospital Medical Board.
12. **"College of Medicine"** means the UAMS College of Medicine.
13. **"Credentials Committee"** means the group of Medical Staff members defined under Article IX of these Bylaws.
14. **"Dean, College of Medicine"** means the individual appointed by the Chancellor to act on the Chancellor's behalf in the overall management of the College of Medicine.
15. **"Department Chair"** means the College of Medicine appointed head of an academic department.
16. **"Disability"** shall have the same meaning as this term is defined in the Americans with Disabilities Act.
17. **"Due Process"** means the various procedures set forth in these Bylaws to ensure fairness when conducting Investigations or other Professional Review Activities and Actions.
18. **"Faculty Appointment"** means an appointment in the College of Medicine at a level of Instructor, Assistant Professor, Associate Professor, Professor, Distinguished Professor, University Professor or one of the above titles modified by Adjunct, Visiting or Emeritus.

19. **“Investigation”**: means a formal, targeted process conducted by a Professional Review Body to obtain facts related to a concern or complaint about a Medical Staff member’s competence or conduct in order to determine whether a Professional Review Action should be requested or recommended.
20. **“Hospital”** means UAMS Medical Center.
21. **“Housestaff”** means an intern, resident, or fellow who is not a member of the Medical Staff and who is receiving post-graduate training at UAMS in (1) a residency or fellowship accredited by the Accreditation Council of Graduate Medical Education and sponsored by the UAMS College of Medicine, (2) a residency or fellowship accredited by the Commission on Dental Accreditation and sponsored by the Center for Dental Education College of Health Professions, or (3) additional accrediting bodies approved by the Hospital Medical Board.
22. **“Integrated Clinical Enterprise (ICE)”** means the governance and delivery system for all clinical care at UAMS Medical Center.
23. **“Medical Board”** means the group of individual Medical Staff appointees defined under Article V of the Bylaws.
24. **“Medical Center”** means UAMS Medical Center.
25. **“Medical Staff”** means all physicians and dentists granted privileges to attend patients at UAMS Medical Center.²
26. **“Peer Review”** means routine professional review activities performed to evaluate the effectiveness and quality of health care rendered by appointees, including initial Focused Professional Practice Evaluations, Ongoing Professional Practice Evaluations and patient safety events or quality reviews performed by Medical Staff committees. Peer review is not an investigation for purposes of Ark. Code Ann. § 20-9-1303(4) or Ark. Code Ann. § 20-9-1301 to 20-9-1308.
27. **“Physician Assistant”** shall have the same meaning as this term is defined in the Arkansas Medical Practices Acts.
28. **“Professional Review Action”** means an action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity and that (i) is based on an individual Medical Staff member’s competence or professional conduct that adversely affects or could adversely affect the health or welfare of a patient or patients: and (ii) adversely affects or may adversely affect the Hospital clinical privileges of the Medical Staff member.
29. **“Professional Review Activity”** means an activity to: (i) determine whether an individual may have clinical privileges at the Hospital; (ii) determine the scope or conditions of such privileges, or (iii) change or modify such privileges. A Professional Review Activity includes an Investigation.
30. **“Professional Review Body”**: means as appropriate to the circumstances, the Board of Trustees, the Hospital Medical Board, the Executive Committee, The Credentials Committee, any Ad Hoc

² HR.01.02.05

Investigation Committee, any Hearing Committee, any Appellate Review Committee, the Hospital Chief Executive Officer, the Hospital CEO, the Chief of Staff, any department, division or service chairman and any other person, committee or entity having authority to make an adverse recommendation with respect to or to take or propose an action against any Medical Staff applicant or Medical Staff member when assisting the Board of Trustees in a Professional Review Activity.

31. **"Reasonable accommodation"** when used in connection with a disability, shall have the meaning ascribed to it in the Americans with Disabilities Act.
32. **"Service Line"** means a functional subdivision of the Integrated Clinical Enterprise (ICE), organized to enhance care delivery goals.
33. **"Service Line Director"** means an administrator of UAMS Medical Center and the Organized Medical Staff responsible for managing medical staff functions as outlined within these Bylaws.
34. **"Summary Suspension"** means a temporary suspension of a Medical Staff member's clinical privileges when there is cause to believe that the member's conduct presents an imminent danger to the health or safety of any individual. A Summary Suspension facilitates preliminary review and inquiry to determine whether a Professional Review Action is warranted, but it is not a complete Professional Review Action and is neither final nor disciplinary. Summary Suspensions must be reported to the appropriate licensing board. Summary Suspensions lasting greater than 30 days must be reported to the National Practitioner Data Bank.
35. **"UAMS Medical Center"** means the Hospital and all clinics and other patient care facilities administered as part of the Medical Center.

Masculine and feminine word forms and pronouns may be used to mean either gender, and plural pronouns are sometimes used in the singular number, to avoid gender bias.

ARTICLE I: NAME

The name of the organization is the Medical Staff of UAMS Medical Center. The organized Medical Staff is accountable to the Medical Board and to the University Of Arkansas Board Of Trustees.

ARTICLE II: PURPOSE

- 2.1.** The Medical Staff is organized to provide a mechanism to ensure a uniform standard of quality patient care, treatment and services, education and research through Rules and Regulations, performance standards, peer review and cooperation. The Bylaws provide a structure in which the Medical Staff can perform its duties and functions.³
- 2.2. The Medical Staff's goals are to:**
- A.** Assure that optimum quality and appropriate health care services are rendered through UAMS Medical Center;
 - B.** Assure appropriate professional performance and utilization of services, within the scope of defined clinical privileges, through systematic credentialing, review, appraisal and improvement;⁴
 - C.** Provide an environment conducive to employment, education and research;
 - D.** Maintain a mechanism to address and resolve medical and administrative issues; and
 - E.** Provide a plan for the Medical Staff's self-governance and accountability to the Board of Trustees.⁵

ARTICLE III: CONDUCT OF MEETINGS

- 3.1. QUORUM AND VOTE.** Except as otherwise specified herein, one-half of the voting membership present of the Medical Board and all Medical Board councils and committees shall constitute a quorum for all actions. Except as otherwise specified herein, action on any matter shall be taken by a majority vote where a quorum is present.
- 3.2. ASSIGNMENT OF RIGHT TO VOTE.** Members of the Medical Board and Medical Board councils and committees (with the exception of the Executive Committee) may assign their right to vote to another member of the Medical Staff (and of the same Clinical Service) provided that such assignment is in writing. Such assignment may be a continuing one designating another member of the Medical Staff

³ MS.02.01.01 EP10

⁴ MS.02.01.01 EP10

⁵ MS.02.01.01 EP9

(and of the same Clinical Service) as an alternate with right to vote in the absence of the Board, Council or Committee member.

- 3.3. **RULES.** Meetings shall be conducted by Roberts Rules of Order.

ARTICLE IV: SERVICE LINES

- 4.1. **SERVICE LINE ORGANIZATION.** The Medical Staff is organized into Service Lines to provide patient service, education and research effectively by grouping Medical Staff administrative units.
- 4.2. **SERVICE LINE FUNCTIONS.** Each Service Line shall have the following functions:
- A. Organize services to provide patient care, education and research specifically related to the Service Line and clinical service;
 - B. Develop and implement a quality assurance and quality improvement program to continuously monitor, evaluate and improve the quality and appropriateness of the care and treatment provided to patients, to include all major clinical activities of the service;
 - C. Schedule periodic staff meetings to: 1) consider findings from quality assurance and quality improvement activities; 2) provide peer assessment and recommendations for action; and 3) inform staff of policies, procedures and current issues;
 - D. Record and maintain minutes, including Medical Staff attendance, of meetings and report regularly on quality assurance and quality improvement activities to committees and councils
 - E. Assist the Medical Board in developing criteria for delineating clinical privileges and credentialing new staff; and,
 - F. Conduct continuing education programs relevant to the services' specialties.
- 4.3. **DUTIES OF SERVICE LINE MEMBERS.** Each practitioner who is an Active Medical Staff member of a clinical service shall:
- A. Regularly attend service and Medical Staff meetings;
 - B. Participate in the service's quality assurance and quality improvement program;
 - C. Participate in the service's utilization review program; and,
 - D. Perform such other duties as the Service Line Director or his/her designee may assign from time to time.
- 4.4. **SERVICE LINE DIRECTOR QUALIFICATIONS.** A Service Line Director shall be appointed by the Medical Center CEO and the Dean of the College of Medicine. Service Line Directors (excluding the Nursing and Pharmacy and Therapeutics Service Lines) shall be active members of the Medical Staff and certified by an appropriate specialty board, or

possess comparable competence as determined by the Credentials Committee.⁶

4.5. DUTIES OF SERVICE LINE DIRECTOR. ⁷Each Service Line Director is an administrative officer of UAMS Medical Center, reporting to the Chief Clinical Officer, Medical Board and CEO and is responsible for the following duties:

- A.** Serve as a member of the Medical Board;
- B.** Plan and recommend goals and objectives for services, plan staffing levels, including a sufficient number of qualified and competent persons to provide care, treatment and service, to the Chief Clinical Officer, Medical Board and CEO;⁸
- C.** Conduct all administrative and clinical functions of a clinical service including selection of a designee to act in his/her absence;⁹
- D.** Conduct continuous surveillance of the professional performance of individuals within their service with delineated clinical privileges and assure that services provided are within the scope of privileges granted to the individual;¹⁰
- E.** Assess and improve the quality of care, treatment, and services and maintenance of quality control programs as appropriate for their respective service;¹¹
- F.** Review credentials, qualifications, experience, ability and current competence of each prospective and current member and Affiliated Health Professional Staff appointee and making recommendations to the Medical Board concerning appointments, reappointments, and clinical privileges;¹²
- G.** Assist the Medical Board in the determination of qualifications, criteria and competence of divisional Medical Staff and Affiliated Health Professional Staff defining required credentials and the criteria for clinical privileges relevant to the care provided by the service;¹³
- H.** Preside at Service Line meetings;
- I.** Develop, implement and enforce Medical Staff Bylaws, Rules and Regulations, UAMS Medical Center's Policies and Procedures and campus policies and procedures that guide and support the provision of care, treatment and services as applicable to the service;¹⁴

⁶ MS.01.01.01 EP36

⁷ MS.05.01.03 EP4,5

⁸ MS.01.01.01 EP36

⁹ MS. 01.01.01 EP36

¹⁰ MS.01.01.01 EP36

¹¹ MS.01.01.01 EP36

¹² MS.01.01.01 EP36

¹³ MS.01.01.01 EP36

¹⁴ MS.01.01.01 EP36

- J. Work with appropriate administrators regarding fiscal affairs of the clinical service, including making recommendations concerning capital equipment which is needed to conduct clinical services;
- K. Coordinate and integrate interdepartmental and intradepartmental services; integrating the service into the primary functions of the hospital; cooperating with the CEO and the Medical Board;¹⁵
- L. Recommend to the Chief Clinical Officer persons to be appointed Physician Director of a clinical service;
- M. Recommend space and other resources needed by the service;¹⁶
- N. Assess and recommend off-site sources for needed patient care, treatment and services not provided by the Service or the Medical Center;¹⁷
- O. Orientation and ongoing relevant education of the clinical service providers in the Department;^{18 19}
- P. Foster UAMS' role in research and education;
- Q. Review, research and respond to physician complaints timely and with appropriate collaboration with Chief Clinical Officer, Chief of Staff and the Dean to resolve complaints; and,
- R. Lead and support activities of the Medical Staff councils and committees.

ARTICLE V: MEDICAL BOARD AND EXECUTIVE COMMITTEE ^{20 21}

- 5.1. **ORGANIZATION.** The primary governing body for the Medical Staff is the Medical Board.
- 5.2. **PURPOSE OF MEDICAL BOARD.** The Medical Board is organized to:
 - 1) allow representation and participation in any deliberations affecting the discharge of Medical Staff responsibilities; 2) assure the quality and appropriateness of patient care; and 3) establish a system of Medical Staff governance with accountability to the Board of Trustees. The Medical Board and its Councils and Committees conduct the functions related to the Medical Staff's responsibilities.^{22 23}

¹⁵ MS.01.01.01 EP36

¹⁶ MS.01.01.01 EP36

¹⁷ MS.01.01.01 EP36

¹⁸ MS.08.01.03

¹⁹ MS.01.01.01 EP36

²⁰ MS.02.01.01 EP1

²¹ MS.01.01.01 EP20

²² MS.02.01.01 EP5

²³ MS.02.01.01 EP10

5.3. COMPOSITION OF MEDICAL BOARD.

A. The Medical Board is composed of:

1. Chief of Staff,
2. Chief of Staff-Elect,
3. Immediate Past Chief of Staff of the Medical Staff,
4. Chief Clinical Officer,
5. Chief Medical Quality Officer;
6. Chief Service Line Officer,
7. Chair of each clinical department in the College of Medicine,

8. Service Line Director of each Service Line (excluding the Nursing and Pharmacy and Therapeutics Service Lines),
9. Five (5) at-large members; and,
10. One (1) Advanced Practice Staff member.

B. The following officials shall be non-voting, ex-officio members of the Medical Board:

1. Chief Residents Council President,
2. Chancellor,
3. CEO,
4. Nursing Service Line Director,
5. Pharmacy and Therapeutics Service Line Director,
6. College of Medicine Dean,
7. Designated Institutional Official of Graduate Medical Education; and,
8. Other members of the Hospital Administration team.^{24 25 26 27 28}

5.4. VACANCIES. Service Line Director vacancies shall be filled by an Acting Service Line Director. A vacancy in the office of the President, Chief Residents Council, shall be filled by the Vice President, Chief Residents Council.

5.5. DUTIES. The Medical Board shall have the following duties:

- A.** Fulfill the Medical Staff's purposes as defined under Article II of these Bylaws;²⁹
- B.** Represent and act on behalf of the Medical Staff, subject to limitations imposed by these Bylaws;³⁰
- C.** Coordinate activities and general policies of various Medical Board Councils, committees and Clinical Services;

²⁴ MS.02.01.01 EP4

²⁵ MS.02.01.01.EP2

²⁶ MS.4.01.01.EP5,7

²⁷ MS.01.01.01 EP19

²⁸ MS.01.01.01 EP22

²⁹ MS.05.01.01 EP1,2

³⁰ MS.01.01.01 EP23

- D. Receive and act upon minutes and reports from Medical Board Councils, committees and clinical services;³¹
- E. Formulate and implement Medical Staff policies within authority;
- F. Facilitate liaison among the Medical Staff; Dean, College of Medicine; CEO; and Board of Trustees;
- G. Recommend action on medical/administrative issues to the CEO and the Board of Trustees;³²
- H. Discharge responsibilities essential to maintaining accreditation and licensure.
- I. Develop and implement an effective quality assurance and quality improvement program which measures, assesses and improves processes involving practitioners credentialed and privileged by the Board of Trustees;^{33 34}
- J. Enforce these Medical Staff Bylaws, Rules and Regulations and the policies and procedures of UAMS Medical Center and UAMS;
- K. Review and revise as indicated the Medical Staff Bylaws, Rules and Regulations every two years; submit revisions to the Board of Trustees for approval; and,
- L. Plan, organize, implement and monitor a program to grant Medical Staff appointment and reappointment, delineate clinical privileges and assign members to clinical services, and,³⁵
- M. Reasonably ensure professional and ethical conduct of every appointee, and
- N. Reasonably ensure competent clinical performance of every appointee.

5.6. TERM OF OFFICE OF MEMBERS OF THE MEDICAL BOARD. The terms of office of the Service Line Directors and the ex-officio members of the Medical Board shall be indefinite. At-large members are appointed for two-year terms; rotating off at the end of their term.

5.7. COMPOSITION OF EXECUTIVE COMMITTEE. Membership of the Executive Committee of the Medical Board is composed of the following: the Chief of Staff; Chief of Staff-Elect; immediate past Chief of Staff; the Chief Clinical Officer; the Chief Medical Quality Officer; the Chief Service Line Officer; and at least three (3) at-large members appointed by the Chief of Staff.

³¹ MS.02.01.01 EP8,10,12

³² MS.01.01.01 EP6

³³ MS.05.01.01 EP1

³⁴ MS.05.01.03

³⁵ MS.02.01.01 EP8,12

- 5.8. DUTIES OF EXECUTIVE COMMITTEE.** The Executive Committee shall have the following duties:
- A.** Act on behalf of the Medical Board and Board of Trustees, subject to ratification of action at the next Medical Board or Board of Trustees meeting;
 - B.** Meet when necessary to review the performance and clinical competence of Medical Staff members;
 - C.** Monitor effectiveness of councils and committees recommending changes to the Medical Board as needed.
 - D.** Annually review/update the hospital's Quality and Safety Plan making recommendations to the Medical Board;
 - E.** Report actions through minutes to the Medical Board;
 - F.** Serve as an advisory body to the Chief of Staff, Chief Clinical Officer and the Medical Board, to facilitate joint clinical initiatives with the UAMS Medical Center; and,
 - G.** Other duties as assigned by the Hospital Medical Board.
- 5.9. MEETINGS OF MEDICAL BOARD AND EXECUTIVE COMMITTEE.** The Medical Board and Executive Committee shall ordinarily meet once each month. The Chief of Staff or the Chief of Staff-elect may call special meetings of the Medical Board or Executive Committee with reasonable notice. Minutes shall be kept, and shall be maintained in the office of the CEO.

ARTICLE VI:
ELECTION OF OFFICERS³⁶

- 6.1. OFFICERS QUALIFICATIONS.** The officers of the Medical Staff are the Chief of Staff and the Chief of Staff-Elect. Officers shall be physician members of the Active Medical Staff at the time of election, and throughout their term of office.
- 6.2 TERM OF OFFICE OF OFFICERS.** The term for office of officers shall be two (2) years beginning July 1 and ending June 30. The Chief of Staff-Elect shall be elected in even years. The Chief of Staff-Elect, if duly elected, shall succeed the Chief of Staff at the end of the Chief of Staff's term of office. In the event there is no duly elected Chief of Staff-Elect at the end of a Chief of Staff's term of office, there shall be an election for Chief of Staff at the same time as the election for Chief of Staff-Elect.
- 6.3. METHOD OF ELECTION.** A Nominating Committee consisting of the Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, Chief Service Line Officer and Chief Clinical Officer is responsible for

³⁶ MS.01.01.01 EP18, EP21

identifying and soliciting nominees for Medical Staff Officers and elected members of the Medical Board (including At-Large Members and the Advanced Practice Staff). The single-transferable-vote system is used for elections. In the first quarter of even years, the Nominating Committee will identify nominees for each position. The subsequent ballot shall be proposed to the Medical Board at the April meeting. Each voting member of the Medical Board will vote on the nominees by marking her/his first, second and third choice on the ballot. The votes will be counted according to policy. In the event of a tie, the Chief of Staff will vote to determine the outcome.

6.4. VACANCIES. Vacancies in the Medical Staff offices shall be filled as follows:

- A. Chief of Staff:** The Chief of Staff-Elect or Acting Chief of Staff-Elect shall serve as Acting Chief of Staff for the remaining term. The Chief of Staff-Elect shall then become Chief of Staff.
- B. Chief of Staff-Elect:** The Executive Committee shall appoint one of its members who is an Active Medical Staff member to serve as the Acting Chief of Staff-Elect for the remaining term. An Acting Chief of Staff-Elect shall not succeed the Chief of Staff unless elected by the Medical Board at the election.
- C. Vacancy in Both Offices:** In the event of a vacancy in both offices, the CEO may appoint an Acting Chief of Staff until the Executive Committee appoints an Acting Chief of Staff and Acting Chief of Staff-Elect to serve the remaining term.

6.5. REMOVAL FROM OFFICE.³⁷

- A. Reasons for removal.** Officers or members at-large may be removed for any of the following reasons:
 - 1. Failure to perform the duties of the office or position as described in these Bylaws;
 - 2. Failure to attend three scheduled meetings of the Medical Board in any one year without reasonable cause; in the case of members of the Executive Committee, failure to attend three scheduled meetings of such Committee without reasonable cause;
 - 3. Termination of Active Medical Staff membership;
 - 4. In the case of a Chief of Staff-Elect, notification of her/his intention of leaving UAMS.
- B. Action of Executive Committee or Medical Board.** Removal because of termination of Active Medical Staff membership or because of notification by a Chief of Staff-Elect of intention to leave UAMS shall not require any action by the Medical Board. The Executive Committee shall declare a vacancy in the office. In the case of removal for some other cause, the Chief of Staff will notify

³⁷ MS.01.01.01 EP21

the involved officer or representative of the allegations. If the involved individual is the Chief of Staff, the Chief of Staff-Elect shall notify the Chief of Staff. The officer/representative may at that point decide to resign from his/her position. If the officer/representative disagrees with the allegations, and wishes the Medical Board to consider the matter, the allegations against the officer/representative shall be presented to the Medical Board. The officer/representative involved shall be entitled to the following due process rights: notification in writing of the allegations and of the date of a hearing before the Medical Board; and the right to be present at the Medical Board meeting where the allegations are presented, to confront her/his accusers, to ask them questions, and to present witnesses in his/her own defense.

- C. Vote on Removal.** An officer/representative may be removed from office by two-thirds vote of all members of the Medical Board who have voting rights. The officer/representative involved in removal proceedings may not vote. The Chief of Staff may vote to break a tie. If the Chief of Staff is the individual involved, the Chief of Staff-Elect may vote to break a tie.
- D. Finality of Medical Board Decision.** The Medical Board decision shall be final, and the involved officer/representative shall have no appeal rights.

ARTICLE VII:
DUTIES OF OFFICERS, ICE CLINICAL OFFICERS, UNIT DIRECTORS

- 7.1. CHIEF OF STAFF.** The Chief of Staff shall have the following duties:
 - A.** Call and chair meetings of the Executive Committee, the Medical Board, and the Medical Staff;
 - B.** Appoint Council and Committee members; and,
 - C.** Address issues and coordinate activities of mutual concern with the Chief Clinical Officer and CEO.

- 7.2. CHIEF OF STAFF-ELECT.** The Chief of Staff-Elect shall have the following duties:
 - A.** Act as Chief of Staff in absence of the Chief of Staff;
 - B.** Serve as voting member of Executive Committee; and,
 - C.** Become Chief of Staff at the end of the previous Chief of Staff's term of office.

- 7.3. ICE CLINICAL OFFICERS: QUALIFICATIONS AND APPOINTMENT.** The Hospital Clinical Officers are the Chief Clinical Officer (CCO), the Chief Medical Quality Officer (CMQO), the Chief Service Line Officer (CSLO) and the Chief Medical Informatics Officer (CMIO). All of the Hospital Clinical Officers are appointed by the CEO. The CCO, CMQO and CSLO are required to be licensed physicians with Medical Center, Medical Staff appointments.

7.4. ICE CLINICAL OFFICERS: DUTIES.

A. CHIEF CLINICAL OFFICER (CCO)

1. Coordinates clinical activities of the Medical Center;
2. Serves as an ex-officio member of all Medical Staff Councils and as a voting member of Executive Committee, Hospital Medical Board and any other Medical Staff Committees naming the CCO as a voting member;
3. Assumes responsibility, in conjunction with the Chief of Staff, Chiefs of Service and the Dean, for enforcing the Bylaws and the Medical Staff Rules and Regulations and for implementing sanctions where indicated;
4. Receives and investigates complaints and concerns about patient care provided by the medical staff;
5. Maintains a collaborative relationship with the Dean of the College of Medicine;
6. Supports the institutional policies on professional behavior;
7. Communicates directly with the Designated Institutional Officer (DIO) regarding graduate medical educational programs;
8. Ensures the successful implementation of effective strategies and approaches for the delivery of high quality, patient- and family-centered care;
9. Shares accountability with the clinical support Service Line directors for clinical outcomes and performance against activity-based budget for all clinical support Service Lines;
10. Works with staff to coordinate resources that impact the delivery of care;
11. Oversees, directs and supports the rendering of medical management decisions; and,
12. Acts as the representative of the Chief of Staff at Board of Trustees meetings.
13. Oversees operations of designated clinical Service Lines and oversees the privileging of Service Line Directors or others as needed.

B. CHIEF MEDICAL QUALITY OFFICER (CMQO)

1. Under the direction of the Board of Trustees and the Hospital Medical Board, provides overall supervision of the quality assurance and quality improvement programs of the Institution;³⁸

³⁸ MS.05.01.01 EP1

2. Works collaboratively with all Service Line Directors and other medical center leadership to lead the institution in the development and measurement of quality/performance excellence and medical safety;
3. Initiates and oversees the development of a comprehensive quality/performance excellence program;
4. Participates in the development, monitoring, reporting and improvement of activities related to clinical pathways and guidelines;
5. Oversees, directs and supports the rendering of medical management decisions; and,
6. Is involved in physician issues involving patient safety, quality infection control, risk management and patient services.

C. CHIEF SERVICE LINE OFFICER (CSLO)

1. Facilitates interaction between the medical staff, medical center administration, its governing board, and the leadership of the Service Lines in order to provide effective and efficient delivery of high-quality, patient and family-centered care;
2. Provides leadership and direction for the development & implementation of institutional performance excellence initiatives;
3. Works in close collaboration with the Vice Chancellor of Clinical Programs and the Service Line Directors to assure the coordination of care between the Service Lines as well as across the various platforms of care;
4. Works in close collaboration with the Vice Chancellor of Clinical Programs, medical center administration, and the support Service Line directors to assure effective and efficient clinical support services;
5. Provides oversight and direction for;
 - a. Development and implementation of the Patient Care Service Line advancement strategy;
 - b. The advancement of patient-care, education and research missions;
 - c. Collaborates with Clinical Enterprise Leadership Council to vet growth opportunities, prioritize resources and advance the institution; and,
 - d. Setting of performance metrics and goals by the Service Line directors;

6. Assists the CMQO in the areas of strategic planning, execution and implementation of care management programs;
7. Works with the CMIO to ensure clinical practice needs are supported by the enterprise information systems;
8. Works with medical administration to coordinate resources that reside in Central Services but impact the delivery of care;
9. Ensures the successful implementation of effective strategies and approaches for the delivery of high quality patient- and family-centered care;
10. Monitors effectiveness of management practices and human resources indicators, such as, turnover rates, absenteeism, budget variance, patient, physician and staff satisfaction surveys;
11. Ensures appointments of medical and affiliated health staff are compliant with sound credentialing practices;
12. Provides critical input regarding the balance needed to support growth initiatives of the various Service Lines;
13. Communicates policies of the Board of Trustees, UAMS Medical Center and the Hospital Medical Board to the medical staff;
14. Makes recommendations to the Credentials Committee concerning appropriate credentials necessary to perform procedures in his/her unit, clinic or program;
15. Works cooperatively with administration to determine staff levels necessary to deliver appropriate care in the unit, clinic or program; and,
16. In conjunction with administration, determines the need for new equipment to provide expected levels of care in the unit, clinic or program.
17. Oversees operations of designated clinical Service Lines and oversees the privileging of Service Line Directors or others as needed.

D. CHIEF MEDICAL INFORMATICS OFFICER (CMIO)

1. Develops strategic plans regarding clinical systems and clinical workflows;
2. Ensures that clinical systems, clinical workflows, and IT developments are in line with global trends in medicine, informatics, and information technology;
3. Engages stakeholders (clinical leaders, executive management, IT, patients/families) through a clinical systems governance process to ensure strategic and tactical alignment of clinical systems with clinical and organizational needs;

4. Plans and oversees strategic organizational transformation and change management strategies using evidence-based informatics tools and processes;
5. Assures the alignment of IT resources, expenditures, hardware, software, and clinical system capabilities with organizational operational and clinical needs;
6. Represents operational and clinical leadership in the strategy, policy development, selection, timing, and rollout of clinical information systems and workflows;
7. Develops strategic plans regarding the institutional data collection and institutional information management;
8. Aligns clinical information system capabilities with organizational operational and clinical needs; and,
9. Oversees the evidence based implementation of clinical information system enhancements and changes, including decision support, documentation/data collection, computerized provider order entry, reporting, and analytics.

7.5. SERVICE LINE LEADERSHIP AND CLINIC PRACTICE DIRECTORS.

Individuals who are selected as Unit or Program Medical Directors or Clinic Practice Directors shall each have a job description for the responsibility to:

- A. Oversee quality of medical care delivered in that unit, clinic or Program;
- B. Recommend to the Credentials Committee concerning appropriate credentials necessary to perform procedures in his unit, clinic or program;
- C. Work cooperatively with Administration to determine staff levels necessary to deliver appropriate care in the unit, clinic or program;
- D. Assure the operation of a facility, which provides equal access to all individuals who have been appropriately designated through the credentialing process to perform procedures in the unit, clinic or program and,
- E. In conjunction with Administration, determine the need for new equipment to provide expected levels of care in the unit, clinic or program.

ARTICLE VIII: MEDICAL BOARD COUNCILS and COMMITTEES^{39 40}

³⁹ MS.03.01.01 EP3,4

⁴⁰ MS.05.01.05

- 8.1 COUNCILS AND COMMITTEES.** Medical Board councils and committees have been formed to participate in discharging the duties of the Medical Board.⁴¹ ⁴² The Medical Board shall develop and approve a charge for each council and committee designating the name, membership, meeting frequency, purpose and responsibilities. The charges shall be made available to Medical Staff members and practitioners with clinical privileges. The councils and committees shall meet regularly, maintain minutes and report their activities to the Medical Board. Special meetings may be called as needed by the Chair. Councils and committees may be created and dissolved in accordance with operational needs and upon recommendation of the Executive Committee and with the approval of the Medical Board.
- 8.2 APPOINTMENT OF COUNCIL AND COMMITTEE MEMBERS.** Council and committee members may be Medical Staff members, other health professionals, administrative staff of UAMS Medical Center, or, from the community. A majority of each council or committee shall be members of the Medical Staff. Unless the council or committee charge specifies that members who are not physicians are non-voting members, they shall be voting members. The Chief Clinical Officer shall be a voting member of the Executive Committee, the Credentials Committee and the Hospital Medical Board; and an ex-officio (non-voting) member of all other councils and committees. Members may concurrently serve on more than one council or committee.
- 8.3 TERM AND REMOVAL.** Council and committee members are appointed for two-year terms, beginning on July 1 of even years and renewing automatically for 2 years on each anniversary of the effective date. The Chair of each council or committee shall provide an annual report to the Chief of Staff and the Chief Clinical Officer. The Chief of Staff may review councils and committees for effectiveness and replace council and committee members as necessary. Re-appointments are encouraged in order to enhance continuity. An appointment shall automatically cease if a member leaves UAMS Medical Center or resigns from the council or committee.

⁴¹ MS.03.01.01 EP1

⁴² MS.05.01.01 EP1,2

- 8.4 VACANCIES.** Vacancies in council and committee membership shall be filled by the council or committee chair. Appointments shall be for the remaining term of the vacancy. Medical Board approval of such appointments is not required.
- 8.5 DUTIES OF MEMBERS.** Council and committee members accept responsibility to:
- A.** Participate in council and committee functions;
 - B.** Attend council and committee meetings;
 - C.** Cooperate with council and committee members; and,
 - D.** Accept voting rights.
- 8.6 CHAIR.** The Chief of Staff shall appoint the Chair of each council and committee. In the event of a vacancy, the Chief of Staff shall appoint an Interim Chair to serve out the remainder of the term. The term will be two years, from July 1 of year one through June 30 of year two. Unless otherwise specified in the committee charge, each Chair must be a member of the Active Medical Staff. The Chair may delegate any duties to another council or committee member.
- 8.7 DUTIES OF THE CHAIR.**
- A.** Schedule meetings, prepare meeting agendas and notify members of meetings;
 - B.** Appoint council or committee members in consultation with the Chief of Staff;
 - C.** Conduct the council or committee's business to fulfill a defined charge;
 - D.** Record minutes and attendance of meetings; distribute minutes; and,
 - E.** Represent the council or committee at the Hospital Medical Board as requested.
- 8.8 REPORTING.** Councils and committees shall have regular business meetings followed by separate quality meetings for discussion of any confidential issues that are before the council. Each council and committee shall keep a record of its minutes and attendance roster. Separate minutes shall be kept for the quality meetings. Minutes will be approved by the membership and signed by the council or committee chair. Business and quality minutes will be maintained in the office of the Chief of Staff or his or her delegate, in the administrative offices of ICE. Councils and committees shall report their activities to the Medical Board and as specified in their charges.

ARTICLE IX: THE CREDENTIALS COMMITTEE

9.1. ORGANIZATION AND PURPOSE. The Credentials Committee has been established as a peer review agent of the Hospital Medical Board to oversee the appointment and reappointment of the Medical Staff and Affiliated Health Professional Staff at UAMS Medical Center.⁴³

9.2. COMPOSITION OF CREDENTIALS COMMITTEE. The composition of the Credentials Committee is defined in the Committee Charge.

9.3. COMMITTEE RESPONSIBILITIES:

A. Conduct Professional Review Activities:

- 1. In the Appointment Process:** (1) Review all applications for appointment and the associated documentation; (2) Assess the applicant's qualifications in relation to those privileges requested; (3) Make recommendations for appointment and privilege delineation; and, (4) Factor focused professional practice evaluation (FPPE) into the appointment process according to hospital policy.
- 2. In the Reappointment Process:** (1) Review all reappointments and the associated documentation; (2) Assess the individual's suitability to continue as a member of the Medical Staff and perform those procedures for which privileges are requested; (3) Make recommendations for reappointment and any changes in privilege delineation; and, (4) Factor ongoing professional practice evaluation (OPPE) information into the decision to maintain existing privileges(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of reappointment and according to policy.
- 3. In Response to Complaints or Concerns about Competency or Professional Conduct:** (1) Review investigation findings; and (2) Recommend Professional Review Actions when necessary.

B. On a perpetual basis: Review and revise Departmental privilege lists as necessary and make recommendations concerning privileging processes for specific procedures.⁴⁴

9.4. MEETINGS OF CREDENTIALS COMMITTEE. The Credentials Committee shall meet monthly. The Chief of Staff or the Chief of Staff-Elect may call special meetings with reasonable notice. Minutes shall be kept, and shall be maintained in the Professional Staff Office.

ARTICLE X: MEDICAL STAFF RESPONSIBILITIES AND CATEGORIES

⁴³ MS.05.01.01 EP3

⁴⁴ Insert language for MS.08.01.01, MS.08.01.03, MS 09.01.01

10.1. GENERAL. Only duly licensed professionals who hold a Medical Staff appointment or temporary privileges (under Article XI) are eligible to render medical care at UAMS Medical Center. Appointment to the Medical Staff is granted by the Board of Trustees through the appointment/reappointment process. Every person practicing the medical profession at UAMS Medical Center by virtue of Medical Staff appointment shall be entitled to exercise only those clinical privileges specifically granted to that person by the Board of Trustees, except in the case of temporary privileges.

10.2. RESPONSIBILITIES OF APPOINTMENT. ⁴⁵ ⁴⁶By applying for and accepting a Medical Staff appointment, the applicant has agreed to:

- A.** Abide by Medical Staff Bylaws, Rules and Regulations, and policies;⁴⁷
- B.** Assist in educational and research activities;
- C.** Adhere to the American Medical Association's Principles of Medical Ethics or the American Dental Association's Code of Ethics and the American College of Surgeons' Principles of Financial Relations in the Professional Care of the Patient;
- D.** Provide patient care services consistent with delineated clinical privileges;
- E.** Appropriately educate, train, and supervise other licensed and non-licensed staff when delegating a medical practice;
- F.** Provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life;
- G.** Demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others;
- H.** Demonstrate the use of scientific evidence and methods to investigate, evaluate and improve patient care practices;
- I.** Demonstrate interpersonal and communication skills necessary to establish and maintain professional relationships with patients, families, and other members of health care teams;
- J.** Demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward his/her patients, their profession and society;
- K.** Demonstrate both an understanding of the context and systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care;
- L.** Participate in activities of the Medical Staff;
- M.** Participate in continuing education;⁴⁸

⁴⁵ MS.03.01.03

⁴⁶ MS.01.01.01 EP15

⁴⁷ MS.01.01.01 EP5

- N.** Participate in and cooperate with quality assurance, quality improvement, and utilization review activities;^{49 50}
- O.** Provide continuity of patient care;
- P.** Accept voting rights;⁵¹
- Q.** Complete and document medical histories and physical examinations as follows:^{52 53}
 - 1.** A medical history and physical examination must be completed within thirty (30) days of, or within the first twenty-four (24) hours after admission to inpatient or observation services, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a member of the Active or Courtesy Medical Staff, Advanced Practice Staff or Housestaff in accordance with hospital policy and state law;
 - 2.** An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services when the medical history and physical examination are completed within thirty (30) days of admission or registration. The updated condition must be completed and documented by a member of the Active or Courtesy Medical Staff, Advanced Practice Staff or Housestaff in accordance with hospital policy and state law, and according to the full content of complete and focused history and physical examinations delineated in hospital policies and procedures;
- R.** Abide by UAMS Medical Center Policies and Procedures;⁵⁴
- S.** In the event an adverse recommendation or action is made with respect to staff status or clinical privileges, exhaust any and all administrative remedies which may be available under these Bylaws before utilizing any other means of obtaining staff status and clinical privileges, including but not limited to legal action; and,
- T.** Inform the Credentials Committee immediately:
 - 1.** If privileges or medical staff membership at any hospital or other healthcare organization are denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed or if any such act is pending;
 - 2.** If charged with or convicted of (including a plea of nolo contendere) a felony;

⁴⁸ MS.12.01.01

⁴⁹ MS.05.01.01

⁵⁰ MS.05.01.03 EP2

⁵¹ MS.01.01.01 EP17

⁵² MS.03.01.01 EP6,8,9,10

⁵³ MS.01.01.01 EP16

⁵⁴ MS.01.01.01 EP5,6

3. Of any challenge, denial, reduction, limitation, suspension, revocation, probation, non-renewal, or voluntary or involuntary relinquishment of any license, certificate to practice medicine, or DEA registration in any jurisdiction , or if any such action is pending;
4. If advised or required by the Arkansas State Medical Board or any other licensing, privileging or credentialing body to seek treatment for physical or mental health condition; and
5. If sanctioned by the Centers for Medicare and Medicaid Services (CMS), or of any other adverse actions reported to the National Practitioners Data Bank.
6. If board certification is denied or not renewed; if your eligibility status changes; or if maintenance of certification is otherwise not met.

10.3. CATEGORIES. Medical Staff appointment shall consist of Active, Courtesy, Honorary and Advanced Practice Staff categories.^{55 56} Housestaff are a unique category of provider, who have completed advanced education and are in the process of completing a residency or fellowship as defined in Article XV of these Bylaws.

10.4. ACTIVE MEDICAL STAFF. The Active Medical Staff shall consist of physicians or dentists duly licensed in Arkansas who regularly treat patients at the Medical Center, and who reside closely enough to the Medical Center to provide continuity of care for their patients. Appointment to the faculty in the College of Medicine does not assure membership to the Medical Staff. Active Medical Staff members shall be assigned to a Clinical Service and have delineated clinical privileges. They shall be eligible to serve on Medical Board councils and committees..

10.5. COURTESY MEDICAL STAFF. The Courtesy Medical Staff shall consist of physicians or dentists duly licensed in Arkansas who may occasionally treat patients at the Medical Center or act as consultants. All members of the Courtesy Medical Staff shall hold faculty appointments in the College of Medicine; shall be assigned to a clinical service and shall have delineated clinical privileges. Courtesy Staff members appointed to councils or committees may serve as voting members.

10.6. HONORARY MEDICAL STAFF. The Honorary Medical Staff shall consist of physicians and dentists who are not active in the Medical Center but are honored by emeritus positions. These may be

⁵⁵ MS.01.01.01 EP12, EP15

⁵⁶ MS.01.01.01 EP22

physicians or dentists who have retired from active practice or who have achieved outstanding accomplishments and reputations and have contributed or can contribute to the development of UAMS Medical Center and UAMS. Honorary Staff appointments shall be initiated upon the applicable Service Line Director or designee's invitation to the respective member. Honorary Staff members shall be assigned to a clinical service, but shall not have any clinical privileges other than such consulting privileges as may be delineated. They shall be eligible for membership and have the right to vote on Medical Board councils and committees. If they have privileges to do so, they may render consultative care for patients. Attendance at clinical service and annual staff meetings shall not be required. To the extent necessary for them to exercise any consultative privileges they may have, Honorary Staff members shall be responsible for keeping current with changes in policies and procedures which are applicable to the assigned clinical service. Unless they have consulting privileges, Honorary Staff members are not subject to the appointment/ reappointment process. If they have consulting privileges, they are subject to the appointment/reappointment process and delineation of privileges.

10.7. ADVANCED PRACTICE STAFF. The Advanced Practice staff shall consist of individuals licensed in Arkansas as either Advanced Practice Registered Nurses (APRNs) or as Physician Assistants (PAs). The Advanced Practice Staff must regularly treat Medical Center patients and reside close enough to the Medical Center to provide continuous care for their patients. The Advanced Practice Staff members must have a licensure appropriate agreement with at least one UAMS employed member of the Active or Courtesy Medical Staff of UAMS Medical Center.⁵⁷ They are eligible for membership on the Medical Board, but they are ineligible to hold office. They are also eligible to serve on Medical Board councils and committees and may vote if so designated in the committee charge.⁵⁸

ARTICLE XI: MEDICAL STAFF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES APPLICATION^{59 60 61 62}

⁵⁷ MS.01.01.01 EP17

⁵⁸ HR.01.02.05

⁵⁹ MS.01.01.01 EP13, EP27

⁶⁰ MS.06.01.03 EP1,4

11.1. GENERAL.⁶³ ⁶⁴ All applications for Medical Staff appointment, reappointment, and clinical privileges shall be submitted in writing on forms obtained from the Professional Staff Office upon request by authorized ICE or Departmental designees on behalf of persons eligible for appointment. The decision to grant or deny privileges or renew existing privileges is an objective, evidence based process. The application process shall be designed to assure high quality patient care, and requires detailed, documented data about the applicant's qualifications, competence and previous experiences. The Hospital Medical Board and Board of Trustees delegate to the Credentials Committee administrative review and approval of procedures implemented by the Professional Staff Office to support and enforce these Bylaws.⁶⁵

11.2. ELIGIBILITY. To be eligible for appointment to the Medical Staff an applicant shall be:⁶⁶

- A.** A graduate of an accredited medical school, dental school, physician assistant program or advanced practice nurse program;
- B.** Licensed to practice medicine, dentistry, as a physician assistant or as an advanced practice nurse in the State of Arkansas;
- C.** A member of the faculty at UAMS or in a licensure appropriate agreement (collaborative or supervised) with a member of the faculty of UAMS; and,
- D.** A United States citizen or a person with an appropriate visa.
- E.** For appointment to the Active Medical Staff or Courtesy Medical Staff,
 - 1.** The applicant shall also have successfully completed an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), Commission on Dental Accreditation (CODA) or a training program deemed acceptable by a certifying member board of the American Board of Medical Specialties (ABMS), and be either
 - a.** board certified or in preparation for board certification, in a cognate specialty or subspecialty board recognized by the ABMS, AOA or the American Dental Association (ADA) which supports the requested privileges; or

⁶¹ MS.06.01.05. EP2,3,4,5

⁶² MS.07.07.01 EP1,2

⁶³ MS.06.01.03 EP2,3

⁶⁴ MS.06.01.05

⁶⁵ MS.06.01.09 EP4

⁶⁶ HR.01.02.05

- A. Willingness to appear for interviews regarding the application;
- B. Authorization for UAMS Medical Center representatives to consult the National Practitioner Data Bank, the Arkansas State Medical Board, and with other individuals and institutions and inspect all material records having information bearing on the applicant's experience, competence, character, ethics and other qualifications for Medical Staff membership;
- C. Release of UAMS Medical Center and its representatives from any liability for their acts or omissions, performed in good faith without malice, while evaluating the applicant's credentials and the application;
- D. Release from liability of all individuals and institutions that provide information to UAMS Medical Center's representatives in good faith and without malice concerning the applicant's experience, competence, character, ethics and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information;
- E. Authorization and consent for UAMS Medical Center's representatives to provide other hospitals, medical associations, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information UAMS Medical Center may have concerning the applicant, and release of UAMS Medical Center and its representatives from liability for so doing, provided that furnishing such information is done in good faith and without malice;
- F. Pledge to provide continuous care for the applicant's patients;
- G. Receipt and understanding of Medical Staff Bylaws, Rules and Regulations, and agreement that the applicant's activities shall be bound by these documents;
- H. Burden to produce requested information for a proper evaluation of the applicant's experience, competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications; and,
- I. Pledge to report notification of a professional liability action, sanctions or adverse actions against the applicant.

11.5. REVIEW PROCESS.^{67 68 69 70}

A. Application Submission to the Professional Staff Office (PSO).

Applications for initial appointment, reappointment, and clinical privileges shall be submitted to the Professional Staff Office which shall review the application for completeness and perform primary source verification of all critical data elements. Reasonable efforts will

⁶⁷ MS.01.01.01 EP14

⁶⁸ MS.06.01.05 EP11

⁶⁹ MS.06.01.07 EP1,2,4,5

⁷⁰ MS.07.01.01 EP5

be made to perform the application review and primary source verifications within 30 calendar days following receipt of a complete application. If an incomplete application is submitted the applicant shall be notified, and shall be responsible for completing and resubmitting the application. The PSO shall not continue the review process until the application is complete. Failure to cure an incomplete application within three (3) months of receipt of notice will be deemed a voluntary withdrawal of the application.

- B.** Information required to be submitted with the application includes, but is not limited to:
 - 1. Malpractice history,
 - 2. Education and training,
 - 3. Behavioral history,
 - 4. Work history,
 - 5. Health Information; and,
 - 6. Quality data.
- C. Review and Recommendation by Credentials Committee:** The Credentials Committee reviews each initial application, reappointment application, Six Month Review and requested changes in privileges and makes a recommendation concerning requested privileges to the Medical Board. If the Credentials Committee's raises a concern or complaint about the professional competence or conduct of an applicant/member during the application review, an Investigation shall be conducted in accordance with Article XIII of these Bylaws, prior to making a recommendation that adversely affects or could adversely affect the applicant/member.
- D. Review and Recommendation by the Medical Board.** Following review by the Credentials Committee, the Medical Board reviews each application and the recommendation of the Credentials Committee and makes a recommendation to the Board of Trustees.
- E. Review and Approval by Board of Trustees.** The Board of Trustees has the ultimate authority to grant or deny clinical privileges and medical staff membership, as long as the decision is supported by substantial evidence and is not discriminatory, nor contrary to these Bylaws. The Board of Trustees shall review reappointments in advance of the expiration of the appointee's effective period of privileges. The Board of Trustees may approve or reject the recommendation of the Medical Board. If the Board of Trustees rejects the recommendation, the matter shall be referred back to the Medical Board for further action consistent with the Board of Trustees decision.⁷¹
- F. Hearing and Appeal Rights.** If at any time during the application review process, a recommendation or decision adversely affects or could adversely affect the applicant/member, the individual shall be

⁷¹ MS.06.01.07 EP8

notified in writing of the hearing and appeal rights set forth in Article XIV.

11.6. ELEMENTS CONSIDERED IN APPLICATION. ^{72 73}

During the application review process, the following elements shall be reviewed by the Credentials Committee before making a recommendation to the Hospital Medical Board regarding membership to the Medical Staff and/or clinical privileges:

A. Information specific to the Applicant:⁷⁴

1. Current licensure, DEA certification (if applicable). Any challenges to licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration.⁷⁵
2. File with National Practitioner Data Bank;⁷⁶
3. Training relevant to the specific practice;⁷⁷
4. Certification status with the applicable specialty board.
 - a. For APRN appointments to the Advanced Practice Staff: applicants shall hold certification by a certifying body approved by the Arkansas State Board of Nursing for licensure. Applicants on a recognized path for board certification may be approved by the Credentials Committee for appointment. Any exceptions to this requirement will be resolved by the Credentials Committee.
 - b. For PA appointments to the Advanced Practice Staff: applicants shall hold certification by the National Commission on Certification of Physician Assistants (NCCPA). Applicants on a recognized path for board certification may be approved by the Credentials Committee for appointment. Any exceptions to this requirement will be resolved by the Credentials Committee. PAs holding full and unrestricted privileges prior to July 1, 2011, and not meeting this requirement shall not be required to hold certification.
5. Current professional, competence, performance, experience and ability;⁷⁸
6. Quality assurance, quality improvement, and utilization review participation;
7. Evidence of physical ability to perform the requested privileges;⁷⁹

⁷² MS.06.01.07 EP1,2,6,7

⁷³ HR.01.02.06

⁷⁴ MS.06.01.05 EP1,8,9

⁷⁵ MS.06.01.03 EP6

⁷⁶ MS.06.01.05 EP7

⁷⁷ MS.06.01.03 EP6

⁷⁸ MS.06.01.03 EP6

8. Health status (including, but not limited to, substance abuse, medical or psychiatric disorders);⁸⁰
 9. Evidence of adverse action taken against the applicant by UAMS or any other facility, certifying body or licensing body;
 10. Cooperation with personnel, patients and other practitioners;
 11. Ethics;
 12. Clinical judgment in the treatment of patients;
 13. Conduct and professional attitude;
 14. Peer and/or faculty review and recommendations;⁸¹
 15. Professional liability insurance coverage (the applicant must furnish satisfactory evidence of at least \$1,000,000 (per medical incident) \$3,000,000 (aggregate) in professional liability coverage with an insurance company acceptable to UAMS Medical Center);
 16. Canceled or refused professional liability insurance coverage; Malpractice claims and lawsuits alleging medical injury.
 17. Copy of an acceptable picture id;⁸²
 18. A statement explaining any voluntary or involuntary termination of Medical Staff membership;
 19. A statement explaining any voluntary or involuntary limitation, reduction, or loss of clinical privileges;
 20. If available, data from professional practice review by an organization that currently privileges the applicant; and,
 21. Collaborative agreements (APRNs), delegation of services agreements (PAs) and prescription protocols as required by licensure and/or hospital policy.
- B. Category of Medical Staff membership;
 - C. UAMS Medical Center's ability to provide adequate facilities and support services for the applicant and the applicant's patients;
 - D. Health care needs of the patient population; and,
 - E. UAMS Medical Center's current need for the expertise offered by the applicant.

Applicants shall not be entitled to Medical Staff appointment or have the right to exercise clinical privileges merely by virtue of the fact that they have: 1) fulfilled eligibility requirements; 2) practiced their profession in this or any other state; 3) been a member of any professional organization; 4) been granted Medical Staff membership and/or clinical privileges at another institution; or 5) are licensed in Arkansas. Gender, race, creed, disability or national origins are not used in making decisions regarding clinical privileges.^{83 84}

⁷⁹ MS.06.01.05 EP6

⁸⁰ MS.06.01.05 EP6

⁸¹ MS.07.01.03 EP1

⁸² MS.06.01.03 EP5

⁸³ MS.06.01.07 EP3

⁸⁴ MS.07.01.01 EP4

11.7. INITIAL APPOINTMENT/SIX (6) MONTH FPPE REVIEWS.⁸⁵

- A.** Following initial appointment to the Medical Staff and granting of clinical privileges, all new members will be placed under FPPE for up to six (6) months. The Service Line Director or designee will conduct the FPPE and report the results to the Credentials Committee.
- B.** Individuals who successfully complete the initial FPPE will be recommended for full appointment to the Medical Staff. Recommendations will be presented to the Hospital Medical Board for approval and to the Board of Trustees for final approval.
- C.** If any concerns about the member's professional conduct or competence are identified during this time, the Service Line Director or designee shall refer the matter to the Chief Clinical Officer to determine if an investigation or other Professional Review Activity is warranted pursuant to Article XIII.

11.8. REAPPOINTMENT.^{86 87}

- A.** General: The effective period of an appointment shall not exceed a two year period. At this time the appointee is eligible for reappointment.⁸⁸
- B.** Reappointment for Two Years: All reappointments shall have a two-year effective period.
- C.** Criteria for Reappointment:⁸⁹ Recommendations for reappointment and clinical privileges delineation shall be based on the following criteria:⁹⁰
 - 1.** Medical Staff Member's:
 - a.** Current licensure, DEA registration or certification (if applicable). Any challenges to licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration;
 - b.** File with National Practitioner Data Bank,⁹¹
 - c.** Board Certification or waiver status – as per board certification requirements from initial appointment and/or any applicable MOC requirements as per specialty board;
 - d.** Current professional competence, performance, experience and ability including relevant practitioner specific data;

⁸⁵ MS.08.01.01 EP1

⁸⁶ MS.07.01.01 EP3

⁸⁷ MS.01.01.01 EP14

⁸⁸ MS.06.01.07 EP9

⁸⁹ MS.06.01.05 EP8,9

⁹⁰ HR.01.02.05

⁹¹ MS.06.01.05 EP7

- e. Quality assurance, quality improvement, and utilization review participation;
 - f. Medical Staff members are required to submit reasonable evidence of current ability to perform privileges. If the Medical Staff member has indicated s/he has a disability, an evaluation of reasonable accommodations for such Medical Staff member shall be made (but no discrimination shall be based on a disability for which reasonable accommodation can be made).
 - g. Health status (including, but not limited to, drug/alcohol abuse);
 - h. Evidence of adverse action taken against the Medical Staff member by UAMS Medical Center or any other facility, certifying body or licensing body;
 - i. Cooperation with personnel, patients and other practitioners;
 - j. Ethics;
 - k. Clinical judgment and technical skills in the treatment of patients;
 - l. Conduct and professional attitude;
 - m. Peer review and recommendations;
 - n. Professional liability insurance coverage (the Medical Staff member must furnish satisfactory evidence of at least \$1,000,000 (per incident) \$3,000,000 (aggregate) in professional liability coverage with an insurance company acceptable to UAMS Medical Center.);
 - o. Canceled or refused professional liability insurance coverage;
 - p. Malpractice claims and lawsuits alleging medical injury;
 - q. Information explaining voluntary or involuntary termination of Medical Staff membership;
 - r. Information explaining voluntary and involuntary limitation, reduction, or loss of clinical privileges;
 - s. Results in patient satisfaction surveys and referring physician satisfaction surveys;
 - t. Collaborative agreements (APRNs), practice agreements (PAs) and prescriptive protocols as required by licensure and hospital policy;
2. Attendance at Medical Staff council, committee and clinical service meetings;
 3. Continuing Medical Education;
 4. Accuracy, timeliness and completion of medical records;
 5. Compliance with policies and procedures of UAMS Medical Center;
 6. Utilization of resources;

7. Efficiencies in patient care and utilization;
8. Service and attendance on Medical Board councils and committees.

D. Application for Reappointment.

1. Approximately six months prior to expiration of the privilege effective period, the Professional Staff Office shall request the staff member to complete a Medical Staff Reappraisal form. Members shall return the completed form to the Professional Staff Office no later than 30 days after it is sent to them. Information requested (from the applicant) includes:
 - a. Completed privilege request forms. New privilege requests shall include justification documentation.
 - b. Documentation of the minimum requirements for Continuing Medical Education activities;
 - c. If the member has indicated s/he has a disability, an evaluation of reasonable accommodations for such person shall be made (but no discrimination shall be based on a disability for which reasonable accommodation can be made).
 - d. Any challenges to licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration;⁹²
 - e. Canceled or refused professional liability insurance coverage.
 - f. Health status (including, but not limited to, substance abuse, medical or psychiatric disorders)
 - g. Malpractice history (claims and lawsuits) alleging medical injury within last two (2) years; and,
 - h. Information concerning the staff member's admitting practices.
2. The Director of the Professional Staff Office, on behalf of the CEO, shall also request reports from the National Practitioner Data Bank, the Arkansas State Medical Board, and from UAMS's Quality Management Department, and shall seek such information from other sources as the CEO deems related to the reappointment application.
3. Applicants for reappointment shall be presented to the Credentials Committee, the Medical Staff Affairs Council, the Medical Board and the Board of Trustees prior to the expiration of effective period of their privileges. To this end, the Professional Staff Office shall make every effort to inform applicants and their Departments of their reappointment schedule allowing the applicants ample opportunity to return their completed application packets in a timely manner. The Professional Staff Office shall

⁹² MS.06.01.05 EP1

forward the completed application packet to the Service Line Director or designee within 15 days of completing credentialing. The Service Line Director or designee will review available clinical performance information and report any concerns about the member's professional competence to the Credentials Committee. .

4. The Professional Staff Office shall communicate approved privileges to the hospital staff within 2 business days of the granting of the privileges.⁹³
5. Providers' non-compliance with any part of the reappointment process may be considered a voluntary relinquishment or may result in suspension of privileges.

11.9. CLINICAL PRIVILEGES.^{94 95}

- A. Medical Staff members shall seek clinical privileges through the appointment/reappointment process defined in this Article.
- B. Criteria for granting or denying privileges will be applied consistently.
- C. Each Medical Staff member shall be entitled to exercise only those clinical privileges specifically granted to such member. Each Service Line Director or designee shall have the responsibility to continually monitor and assure that all Medical Staff members with clinical privileges within the respective service shall provide only those services within the scope of privileges granted. The Medical Board shall have responsibility to assure the provision of the same level of quality patient care by all individuals with delineated clinical privileges within and across clinical services and among all Medical Staff members. The Medical Board shall conduct this responsibility through the established quality assurance program.
- D. All Active or Courtesy Medical Staff members are automatically granted privileges to: 1) Admit patients according to their privileges and treat inpatients and outpatients; 2) Order diagnostic and therapeutic services, except as noted in Medical Staff Bylaws, Rules and Regulations or Hospital Policy; 3) Document orders and progress notes in the patient's medical record; 4) Request consultation; 5) Provide consultation within the scope of their privileges; and, 6) Render any care, without regard to delineation of privileges, in a life-threatening emergency. Honorary Medical Staff members shall only have the privileges which have been specifically delineated for a particular Honorary Staff member, and in no event shall have any privileges other than specifically delineated consulting privileges.
- E. All Advanced Practice Staff members are automatically granted privileges within their scope of practice to: 1) Provide inpatient and outpatient care according to their privileges; 2) Order diagnostic and

⁹³ MS.06.01.09 EP3

⁹⁴ MS.06.01.05 EP10,12

⁹⁵ MS.01.01.01 EP15

therapeutic services except as noted in Medical Staff Bylaws, Rules and Regulations or Hospital Policy; 3) Write Orders and progress notes in the patient's medical record; 4) Request Consultation; and, 5) Provide consultation within the scope of their privileges.

- F. Practitioners who prescribe, render a diagnosis or otherwise provide clinical treatment to UAMS patients via telemedicine are subject to the credentialing and privileging processes described herein. The Medical Board shall determine which clinical services can be provided by telemedicine.
- G. Every patient shall be under the care of a member of the Active or Courtesy Medical Staff. The responsibility cannot be delegated to any person who is not a member of the Active or Courtesy Medical Staff.
- H. If clinical privileges necessary for quality patient care are removed, the member's patients will be reassigned to another Medical Staff member by the respective Service Line Director or designee to assure that medical care will not be interrupted. The wishes of the patient will be considered in choosing a substitute Medical Staff member.

11.10. TEMPORARY PRIVILEGES.⁹⁶

Temporary Privileges may be granted but shall not exceed 120 days. Upon recommendation of the Chief Clinical Officer or his/her designee, the CEO or his/her designee may grant the following temporary privileges.⁹⁷

- A. Temporary Privileges Granted for an Important Patient Care Need.**⁹⁸ On a case by case basis, temporary privileges may be granted to an individual for an important patient care, treatment and service need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. These privileges require that, at a minimum, current licensure and current competence are verified. In the absence of a complete application with verification of relevant training, experience and references, competence may be established by a written statement from the Service Line Director or designee delineating the applicant's relevant training and experience.
- B. Temporary Privileges Granted for New Applicants.**⁹⁹ Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Board upon previously stated elements considered in the application, including, but not limited to a complete application, current licensure, relevant training and experience, current competence, ability to perform the privileges requested, NPDB query, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of Medical Staff

⁹⁶ MS.06.01.13 EP1

⁹⁷ MS.06.01.13 EP4,5,6

⁹⁸ MS.06.01.13 EP2

⁹⁹ MS.06.01.13 EP3

membership at another facility, no subjection to involuntary limitation, reduction, denial or loss of clinical privileges.

- C. Temporary Visiting Privileges.** Licensed practitioners who are not applicants for the Medical Staff may be granted temporary visiting privileges. Such privileges may be granted at the request of a Service Line Director or designee by the CEO following review and approval by the Chief Clinical Officer as the designee of the Chief of Staff. Practitioners with visiting privileges shall practice under the direct supervision of the appropriate Service Line Director or designee or his/her designee. They shall not have admitting privileges. Such privileges shall be specific as to the patient, procedure, dates and the Medical Staff member who will supervise the visiting staff member. These privileges require that, at a minimum, current licensure and current competence are verified and a current CV, proof of malpractice coverage and NPDB verification are obtained. Such privileges apply only to those professionals who will be directly caring for patients and does not apply to individuals who may observe procedures for educational purposes.

11.11. LEAVE OF ABSENCE.

- A.** A Medical Staff member may request a leave of absence up to one year. The Medical Board shall have authority to grant or deny requests for leaves of absence and extensions of leave. During the leave of absence, unless otherwise specified by the Medical Board, the individual shall continue to be a Medical Staff member with full clinical privileges. If the time for reappointment occurs during the leave of absence, the member may defer the reappointment process until his/her return from leave of absence.
- B.** The reappointment process for a member who has been on a leave of absence shall include disclosure of complete information concerning the member's practice and activities during the leave period, and if the practitioner was not performing clinical duties, a focused professional practice evaluation may be necessary upon resumption of clinical duties.
- C.** Medical Staff membership and clinical privileges of any member who does not return from a leave of absence within one year shall automatically terminate unless an extension is granted by the Medical Board. If the individual wishes to return to the Medical Staff, he/she must complete the procedure for initial appointment.

11.12. CHANGE IN PRIVILEGES.¹⁰⁰

Members requesting revisions to clinical privileges must submit documentation from his/her Service Line Director or designee supporting

¹⁰⁰ MS.06.01.05 EP7

the request and addressing the Member's competency, evidence of adequate training and experience, and any completed forms applicable to the request. The Professional Staff Office will conduct an NPDB query in conjunction with the request.

11.13. DISASTER PRIVILEGES.

Disaster privileges may be granted when the emergency management plan has been activated and the Medical Center is unable to meet the immediate patient care needs. Disaster privileges may be granted by the CEO (or his/her designee), the Chief of Staff (or his/her designee), or the Chief Clinical Officer (or his/her designee), however, disaster privileges are not a right, and the person considering granting the privileges is not required to do so. Decisions will be made on a case-by-case basis at his or her discretion and upon presentation of a valid picture ID issued by a state, federal, or regulatory agency and at least one of the following:

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

Practitioners receiving disaster privileges will be easily identifiable as having disaster privileges with easily identifiable approved volunteer badges and assigned to a designated area supervised by a physician with Active or Courtesy privileges. It will be the priority of the Professional Staff Office to immediately begin the credentialing process of providers receiving disaster privileges and will follow the procedures used for granting temporary privileges to meet an important patient care need. A log of practitioners receiving disaster privileges will be kept with the badges. Primary source verification of licensure of those providers who provided care, treatment and services will begin as soon as the immediate situation is under control and will be completed within 72 hours (if possible) from the time the volunteer practitioner presented to

the organization. In the extraordinary event that verification cannot be completed in 72 hours, it will be done as soon as possible.

Within 72 hours of initially granting the privileges, the physician supervising the area in which the volunteer was assigned will evaluate the volunteer's performance through direct observation, interviews with staff, mentoring, clinical record review, etc., and determine, at that time, if privileges are to be continued. Any privileges granted during a disaster will automatically terminate when the disaster is declared to have ended.

ARTICLE XII: AUTOMATIC TERMINATION AND SUSPENSION¹⁰¹¹⁰²¹⁰³

12.1. AUTOMATIC TERMINATION

Automatic termination occurs in response to the issues that by definition implicate the affected Member's basic qualifications to practice at UAMS. Automatic termination of a Member is not subject to hearing or appeal. Termination of a Member's clinical privileges and Medical Staff appointment shall automatically occur under the following circumstances:

- A.** Revocation, expiration or suspension of license to practice;
- B.** Failure to achieve board certification within the time limits prescribed by these Bylaws or being found ineligible for further preparation for board certification;
- C.** Failure to cure any lapse in maintenance of board certification within two (2) years of the expiration of certification or designation of not meeting maintenance of certification;
- D.** Involuntary exclusion from participation in Medicare, Medicaid or other federally funded health care programs;
- E.** Termination of the Member's faculty appointment in the College of Medicine;
- F.** Conviction of a felony; or,
- G.** Failure to satisfactorily complete the program of therapy or monitoring for substance use, medical or psychiatric disorders deemed necessary by the Medical Staff Health Committee (MSHC) and/or failure to comply with the terms of an on-going monitoring agreement with the MSHC for substance use, medical or psychiatric disorders.

A request for reinstatement may be made following the end of a disqualifying event. Requests made less than one (1) year after the automatic termination will be considered a reapplication for appointment. Requests made greater

¹⁰¹ MS.01.01.01.EP28

¹⁰² MS.02.01.01 EP6

¹⁰³ MS.01.01.01 EP30

than one (1) year after automatic termination will be considered an initial application for appointment.

12.2 AUTOMATIC ADMINISTRATIVE SUSPENSION

The following will result in automatic suspension of Medical Staff membership and/or clinical privileges and will not, unless otherwise expressly provided or required by law, entitle the affected member to the due process rights provided for in Article XIV of these Bylaws. Medical Staff members on leave of absence are not subject to automatic suspension during their leave period.

- A.** In the event a Medical Staff member's license authorizing him/her to practice in this State is revoked, stayed, suspended, or subject to probation, the action and its terms shall automatically apply to his/her Medical Staff membership and/or clinical privileges as appropriate. Such an action by the State Medical Board may trigger an Investigation pursuant to Section 13.3. If a Medical Staff member's license expires, the member will automatically be suspended from practice until there is evidence of license renewal.
- B.** In the event a Medical Staff member's DEA certificate is revoked, suspended, stayed, restricted or subject to probation, the action and its terms will automatically apply to his/her right to prescribe, dispense or administer medications covered by the certificate. Such an action by the DEA may trigger an Investigation pursuant to Section 13.3. Whenever a Medical Staff member's DEA certificate expires, the member's right to prescribe, dispense, or administer medications covered by the certificate will be automatically suspended until there is evidence of certificate of renewal.
- C.** A Medical Staff member's clinical privileges to admit patients and schedule procedures shall be automatically suspended for failure to comply with documentation requirements set forth in the Medical Records Documentation policy upon the expiration of ten (10) calendar days of receipt of written notice of delinquent medical records. Privileges may remain suspended until all delinquent medical records are completed. Failure to complete records within three (3) months of the date of suspension will be deemed a voluntary resignation from the Medical Staff.
- D.** Failure to maintain professional liability insurance as required by these Bylaws will result in automatic suspension of clinical privileges until there is evidence that such insurance has been secured. Failure to provide such evidence within three (3) months of the date of suspension will be deemed a voluntary resignation from the Medical Staff.
- E.** Failure to comply with UAMS Medical Center mandatory training, health screening and immunization requirements will result in automatic suspension of clinical privileges until the deficiency is cured.

- F. Automatic suspension of a Medical Staff member is not subject to hearing or appeal.
- G. Automatic suspensions will be reported to the appropriate Department Chair, Service Line Director or designee and Credentials Committee. Medical Staff members who have repeated automatic suspensions are subject to disciplinary action in accordance with UAMS employment policies.

12.3. SUMMARY SUSPENSION.¹⁰⁴¹⁰⁵¹⁰⁶

- A. The Executive Committee or any two of the following individuals shall have the authority to summarily suspend all or part of the clinical privileges of a Medical Staff member whenever there is cause to believe that the member's conduct results in an imminent danger to the health or safety of any individual: the Chief of Staff, a Service Line Director or designee, the Chief Clinical Officer (or on-call designee), the Department Chair of the Department to which the provider reports, and the CEO or on-call designee. Such Summary Suspension shall become effective immediately upon imposition.
- B. The Chief Clinical Officer shall be immediately notified any time a Summary Suspension is imposed and shall initiate an investigation in accordance with Article XIII of these Bylaws to determine if there is a need for Professional Review Action.
- C. Summary Suspensions lasting fourteen (14) days or less are not considered an adverse action and are not subject to hearing or appeal. Summary Suspensions lasting greater than fourteen (14) days are subject to hearing or appeal as set forth in Article XIV.

12.4. PATIENT REASSIGNMENT. If an automatic termination or suspension results in removal of clinical privileges necessary for quality patient care, the involved individual's patients will be reassigned to another Medical Staff member by the respective Service Line Director or designee to assure that medical care will not be interrupted. The wishes of the patient will be considered, when feasible, in choosing a substitute Medical Staff member.

ARTICLE XIII: PROFESSIONAL CORRECTIVE ACTION¹⁰⁷

13.1. BASIS FOR PROFESSIONAL REVIEW ACTION.¹⁰⁸ The Medical Staff Organization shall assume responsibility for Professional Review Actions whenever it appears that the competence or professional conduct of any applicant/appointee:

¹⁰⁴ MS.01.01.01 EP29

¹⁰⁵ MS.01.01.01 EP31

¹⁰⁶ MS.01.01.01 EP32

¹⁰⁷ MS.01.01.01 EP33

¹⁰⁸ MS.01.01.01 EP30

- A. Jeopardizes, or may jeopardize, the safety, best interest, quality of care, treatment or services of a patient, or the safety or best interests of a visitor or employee;
- B. Presents a question regarding the competence, character, judgment, ethics, adequacy of mental or physical health, or ability to work cooperatively with others in the provision of safe patient care, treatment and services;
- C. Violates these Medical Staff Bylaws, Rules and Regulations or UAMS Medical Center policies or procedures; or
- D. Disrupts or has the potential to disrupt the operations of UAMS Medical Center.

13.2. EXAMPLES OF PROFESSIONAL REVIEW ACTIONS. ¹⁰⁹

- A. Examples of a Professional Review Action include, but are not limited to, the following:
 - 1. Denial of initial appointment to a qualified applicant (as is defined in Article XI);
 - 2. Denial of reappointment to a qualified applicant (as is defined in Article XI);
 - 3. Adverse actions related to clinical privileges, including:
 - a. Restriction or limitation of privileges, including but not limited to requirements for monitoring, mentoring, proctoring or remediation for a specific period of time;
 - b. Termination, reduction or revocation of privileges previously granted (except under Section 12.1 and 12.2);
 - c. Probation or suspension of clinical privileges until completion of specific conditions or requirements;
 - d. Limitation of prerogatives related to the member's delivery of safe patient care, treatment and services;
 - e. Suspension of Medical Staff membership for longer than fourteen (14) days; or
 - f. Revocation of Medical Staff membership.

- B. The following actions are not Professional Review Actions entitling the affected person to hearing and appeal rights:
 - 1. Denial of Medical Staff membership or clinical privileges where the applicant does not meet the minimum eligibility or competency requirements as delineated in these Bylaws or the applicable clinical privilege form;
 - 2. Disciplinary action, such as a letter of warning or reprimand, probation, suspension, or termination, for an employment issue unrelated to professional competence;
 - 3. Automatic termination or suspension under Sections 12.1 or 12.2; or

¹⁰⁹ MS.06.01.09 EP2

4. Denial of or failure to renew a specific type of clinical privilege for reasons other than professional competence, such as an administrative decision that a privilege will be limited to a particular specialty or will not be performed at UAMS.

13.3. INVESTIGATIONS.

- A.** A request for an Investigation to review the professional conduct or competence of a Medical Staff member or applicant raising a question under Section 13.1 may be submitted by any Medical Staff member or committee or the CEO. An Investigation is a Professional Review Activity, and any request for such must be made in good faith and supported with written reference to the specific concern, complaint or conduct alleged. Requests should be submitted to the Chief Clinical Officer who will review the request to determine whether an Investigation is warranted. If an Investigation is initiated, the affected member will be promptly notified in writing. Imposition of a Summary Suspension shall automatically trigger an Investigation.
- B.** The Chief Clinical Officer, or his/her designee, shall assign a Professional Review Body to conduct the Investigation.
- C.** The Investigation may be performed through a focused professional practice evaluation or other appropriate process and shall proceed and be completed as expeditiously as possible. The Professional Review Body shall have the authority to inspect all relevant records and reports, interview individuals having relevant knowledge of the matters considered, and interview the involved individual. Any interviews shall be conducted without attendance of counsel, and a record of the interview shall be made. Procedural rules for a formal hearing shall not apply to an Investigation.
- D.** A written report of the Investigation which includes all relevant information reviewed by the Professional Review Body and its findings shall be prepared and a copy provided to the involved individual and the Credentials Committee.
- E.** The Credentials Committee will review the Investigation findings as soon as practical after the conclusion of the Investigation and make a recommendation to the Executive Committee.
- F.** The involved individual shall be given the opportunity to discuss the findings with the Credentials Committee before any actual or potential adverse action is recommended.
- G.** If at any stage of the Investigation, an attorney is participating on behalf of UAMS Medical Center, the involved member shall also be permitted to have independent legal counsel participating in the activity.¹¹⁰
- H.** If a Professional Review Action is recommended based on the results of the Investigation, the affected individual shall be given written notice

¹¹⁰ Ark. Code Ann. § 20-9-1304(c)(1a)

of the recommendation; the basis for the recommendation; and the right to a hearing as set forth in Article XIV.

13.4. PROFESSIONAL REVIEW ACTIONS.

- A.** The Executive Committee will review the Investigation findings and recommendation of the Credentials Committee and determine whether to propose a Professional Review Action.
- B.** The involved individual shall be given the opportunity to discuss the recommendation with the Executive Committee before a Professional Review Action is proposed.
- C.** Whenever the Executive Committee proposes a Professional Review Action, the involved individual shall be given written notice of the decision, the basis for the decision and the right to a hearing as set forth in Article XIV. Notice will be provided as soon as possible after the decision is made. A copy of the notice shall also be sent to the Chief of Staff, respective Department Chair, Service Line Director or designee and Dean of the College of Medicine.¹¹¹
- D.** All Professional Review Actions proposed by the Executive Committee shall be communicated to the Medical Board in writing. The Medical Board will affirm, modify or reverse the decision. No final action will be taken until the involved individual has waived or exhausted his/her hearing and appeal rights pursuant to Article XIV.

ARTICLE XIV: HEARING AND APPEAL ¹¹² ¹¹³

14.1. GROUNDS FOR HEARING. Any proposed Professional Review Action shall constitute grounds for a hearing.

14.2. REQUESTS FOR HEARING.¹¹⁴ ¹¹⁵

- A.** A petitioner will have thirty (30) days following the date of receipt of notice of a proposed Professional Review Action to request a hearing. The request must be in writing and delivered to the Chief of Staff. Failure to request a hearing within thirty (30) days will be deemed to constitute voluntary waiver of any hearing rights and acceptance of the decision. Thereupon, the decision shall be forwarded to the Board of Trustees and shall be immediately effective and final.
- B.** Upon receipt of a request for a hearing, the Chief of Staff shall appoint an ad hoc hearing committee and schedule a hearing within thirty (30) calendar days from the date of the request, unless further delay is

¹¹¹ MS.06.01.09 EP5

¹¹² MS.01.01.01 EP34

¹¹³ MS.10.01.01

¹¹⁴ MS.10.01.01 EP2

¹¹⁵ MS.10.01.01 EP3,4

agreed upon by both the Chief of Staff and the petitioner. Notice will be given to the petitioner of the time, place and date for the hearing.

- C. The Chief of Staff and petitioner shall provide each other with a list of witnesses expected to testify at the hearing at least ten (10) days prior to commencement of the hearing.
- D. The Chief of Staff shall select a hearing committee of five (5) members of the Active Medical Staff. A third party Hearing Officer or Arbitrator shall not be used. A staff member who actively participated in the Professional Review Activity or Professional Review Action or who is in direct economic competition (i.e., within the same sub-specialty) with the petitioner shall not be appointed as a member of the hearing committee. The Chief of Staff shall appoint one member of the hearing committee to serve as Chair. The petitioner shall be afforded a reasonable opportunity to challenge the impartiality of any member of the hearing committee.¹¹⁶
- E. Postponements of time beyond the times expressly permitted in these Bylaws may be requested by the petitioner and will be permitted by the Chief of Staff or hearing committee on a showing of good cause.

14.3. CONDUCT OF HEARING.

- A. It will be the duty of the petitioner and the Executive Committee to raise any procedural objections before the hearing so that decisions can be made in a timely manner. Any objections raised will be preserved for consideration at any appellate review hearing that may be subsequently requested.
- B. The hearing provided for in these Bylaws is for the purpose of intra-professional resolution of matters bearing on professional conduct or competence. Any relevant evidence, including hearsay, will be admitted regardless of admissibility in a court of law. The Chair of the hearing committee shall have the authority to (1) rule on questions of procedure; (2) rule on admission and exclusion of evidence; (3) draft the findings and recommendations of the hearing committee; and (4) generally advise the committee on the discharge of its functions.
- C. A record of the hearing will be made by a certified court reporter. The cost of the reporter will be borne by the hospital. The cost of any transcript requested will be borne by the requesting party.
- D. Both the Executive Committee and the petitioner have the right to representation by an attorney or other person at the hearing. Each party shall have the right to attend the hearing, present evidence, question witnesses who are present and submit written supporting statements at the close of the hearing. The hearing committee may have an attorney present to advise it and may also question witnesses or call additional witnesses at its discretion.

¹¹⁶ MS.01.01.01 EP35

- E. The Executive Committee must present evidence supporting its proposed action and the petitioner will bear the burden of persuading the hearing committee by the substantial weight of evidence provided at the hearing that the decision of the Executive Committee was not supported by substantial evidence. Upon receipt of all evidence and argument, the hearing will be closed.
- F. Failure of the petitioner to appear without good cause at a hearing will be deemed to constitute voluntary waiver of any hearing rights and acceptance of the decision. Thereupon, it shall be forwarded to the Board of Trustees and shall be immediately effective and final.

14.4. ACTION OF HEARING COMMITTEE. The hearing committee will conduct deliberations and render a written decision based on the record produced at the hearing within thirty (30) days. The decision will contain findings of fact sufficient to support the basis for the committee's decision on each matter contained in the notice of action. The decision will be delivered to the petitioner, Chief of Staff, Executive Committee and Board of Trustees. The decision of the hearing committee may be appealed as provided in Section 14.5.

14.5. APPEAL OF PROFESSIONAL REVIEW ACTION¹¹⁷

- A. Whenever a decision of the hearing committee is adverse to the petitioner, such person has the right to appeal the decision to the Board of Trustees. No petitioner is entitled to more than one evidentiary hearing and appellate review on any Professional Review Action.
- B. The petitioner must submit written notice of appeal stating the reason for appeal to the Chief of Staff within ten (10) calendar days of receipt of the adverse decision. The reasons for an appeal of the hearing committee decision shall be: (1) lack of compliance with the procedures required by these Bylaws at the hearing so as to deny the petitioner a fair hearing; and/or (2) the action was not supported by substantial evidence.
- C. The Chief of Staff shall notify the Chairman of the Board of Trustees of the appeal. The Board of Trustees will set a date for the appellate review and will give both parties notice of the time, place and date of the review. The date of appellate review will not be less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appeal. The time for appellate review may be extended by the Board of Trustees for good cause.
- D. When an appellate review is requested, the Board of Trustees may sit as the appeal board or may appoint an appeal board of at least three (3) individuals from its members.
- E. The proceedings on appeal shall be based on the hearing committee record. The appeal board may accept additional evidence subject to a showing that such evidence could not have been made available to the

¹¹⁷ MS.10.01.01 EP5

hearing committee in the exercise of reasonable diligence. Each party will have the right to present a written statement in support of its position. The appeal board, at its sole discretion, may allow each party or representative to appear personally and make oral argument. Following receipt of all evidence, the appeal board will conduct deliberations outside of the presence of the appellant and respondent and their representatives to determine whether the decision was supported by substantial evidence and appropriate procedures were followed.

- F.** Within ten (10) calendar days after the conclusion of the appellate review proceedings, the appeal board will render a decision in writing, which shall be the decision of the Board of Trustees. The Board of Trustees may affirm, modify or reverse the decision of the hearing committee or remand the matter for further review and recommendation within a time frame determined by the Board. The decision of the Board of Trustees shall be immediately effective and final and not subject to further hearing or appeal.
- G.** Written notice of the final decision shall be provided to the petitioner and Chief of Staff to be presented to the Executive Committee. Copies of the decision shall also be sent to the respective Service Line Director or designee and Department Chair, Dean of the College of Medicine and Professional Staff Office.

ARTICLE XV: HOUSESTAFF

15. HOUSESTAFF¹¹⁸

- A.** The "housestaff" shall consist of individuals who are appointed to
 1. the College of Medicine Residency Program and have been assigned clinical rotation at UAMS Medical Center according to Graduate Medical Education Committee Policy on Recruitment and Appointment, or
 2. residency programs sponsored by the Center for Dental Education College of Health Professions.
- B.** The housestaff are eligible to serve on councils and committees and to function in the clinical areas of UAMS Medical Center within the limitations of their appointment. The housestaff are not eligible to admit patients. The housestaff cannot function as Active or Courtesy Medical Staff members as defined in the Medical Staff Bylaws and are not voting members of the Medical Staff¹¹⁹.
- C.** The Service Line Director or designee is responsible for insuring that each housestaff member is supervised by a member of the Active or Courtesy Medical Staff within his/her service. The Service Line Director or designee shall establish patient care activities consistent with

¹¹⁸ MS.04.01.01 EP1

¹¹⁹ MS.01.01.01 EP17

ACGME guidelines that can be carried out by housestaff. Within such parameters, members of the Active or Courtesy Medical Staff may delegate certain duties and responsibilities according to the individual housestaff member's capabilities and experience. Members of the Active and Courtesy Medical Staff are directly responsible for all housestaff patient care activities. Housestaff members may also be supervised by upper level housestaff members as well as their assigned Active or Courtesy Medical Staff member. The housestaff are directly responsible to upper level housestaff and assigned to Active or Courtesy Medical Staff members, as well as to their respective Service Line Director or designee to the Chief of Staff, and to the Chief Clinical Officer for clinical aspects of patient care and pertinent UAMS Medical Center policies.

- D. Housestaff members are not privileged members of the Medical Staff and are not afforded due process as defined in these Bylaws.

ARTICLE XVI : MEDICAL STAFF MEETING

- 16.1. The Medical Staff shall meet as deemed appropriate by the Chief of Staff. The Chief of Staff shall preside.

ARTICLE XVII: AFFILIATED HEALTH PROFESSIONAL STAFF

17.1. GENERAL

- A. Affiliated Health Professional Staff appointees shall be health professionals: (1) who hold health care related advanced degrees or have a proven skill in the area of their specialty and (2) who are performing clinical duties and patient services under the supervision of a member of the Medical Staff who is responsible for supervision of their clinical performance.
- B. The Affiliated Health Professional Staff is a separate staff from the Medical Staff. Affiliated Health Professional Staff appointees are not members of the Medical Staff, and no Affiliated Health Professional Staff appointee shall be eligible to hold office or vote as a Medical Staff member.¹²⁰
- C. Affiliated Health Professional Staff appointees shall not have admitting privileges, and shall render services to a patient only if a Medical Staff member has ultimate responsibility for and authority over the care of the patient. Under these conditions, an Affiliated Health Professional Staff appointee may:
 - 1. Participate directly in the management of the patient;
 - 2. Exercise judgment with his/her area of competence;

¹²⁰ MS.01.01.01 EP17

- 3. Perform services within his/her area of professional qualification, competence and according to his/her approved job description; and,
- 4. Record reports and progress notes in the patient's record.
- D. Affiliated Health Professional Staff appointees shall attend regularly scheduled meetings of the clinical service to which they are assigned..
- E. The Affiliated Health Professional Staff is divided into Consulting Scientist and Allied Health Personnel.
- F. Each Affiliated Health Professional Staff appointee shall have a "sponsoring physician" who shall be a member of the Active or Courtesy Medical Staff. In the case of Consulting Scientists, the sponsoring physician will ordinarily be the Service Line Director or designee to which the Consulting Scientist is assigned. In the case of Allied Health Personnel, the sponsoring physician may be the Service Line Director or designee or the physician who is directly responsible for their supervision.
- G. Each Affiliated Health Professional shall be assigned to a clinical service and shall be authorized to provide care with definitive lines and level of supervision delineated in writing. Authorization to provide care may be granted to Affiliates and shall be consistent with their profession, licensure, experience and competence.

17.2. CATEGORIES. Affiliated Health Professional Staff shall consist of Consulting Scientists and Allied Health Personnel.

- A. CONSULTING SCIENTISTS.** Consulting Scientists are doctoral-level scientists and licensed health professionals with doctoral degrees such as, but not limited to, psychologists, podiatrists, laboratorians and physicists who: (1) by their licensure (or other comparable certification), are eligible to provide patient care services without direction or supervision and /or (2) are graduates of a doctoral program in a profession accredited by a nationally recognized accrediting body approved by the U.S. Office of Education. While they may not admit patients, Consulting Scientists may be authorized to consult in relation to patients to whom their special consulting scientist skills may be useful and in activities of education and research.
- B. ALLIED HEALTH PERSONNEL.** Allied Health Personnel shall be licensed health professionals such as, but not limited to, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Professional Counselors, and highly trained health professionals for whom licensure is not available in Arkansas, who (1) may or may not be licensed to practice independently and (2) are performing clinical duties and patient services under the direction of a sponsoring Medical Staff member who is responsible for supervision of their clinical performance.

17.3. APPOINTMENT PROCESS - General.

- A.** Affiliated Health Professionals shall make application for initial appointment, reappointment and authorization to provide care. This application will be submitted to the Professional Staff Office, which is acting on behalf of the CEO, where it will be reviewed for completeness as well as to verify the accuracy of the data provided. The complete application shall consist of:
1. An application completed and signed by the applicant;
 2. Verified current Arkansas licensure/certification, if applicable.¹²¹
 3. Health status (including, but not limited to, substance abuse, medical or psychiatric disorders);
 4. Documentation of education and/or training to perform clinical activities, which shall be verified by virtue of licensure where education is required and verified by the licensing body; through written statement of the sponsoring physician; or directly with the institution conferring the degree;
 5. Three peer references;
 6. If the applicant is not an employee of the State of Arkansas, the applicant must also provide proof of professional liability insurance coverage reasonably satisfactory to the CEO or proof that the applicant's employer's insurance policy will cover the applicant's acts or omissions at UAMS Medical Center;
- B.** Each applicant must also complete a job description signed by his/her sponsoring physician whereby the physician agrees to accept responsibility and accountability while the applicant is performing assigned duties within the Medical Center. The job description should specifically delineate the procedures which the applicant will be performing and provide a summary of the expected scope of practice for the applicant.
- C.** Once a standardized job description with requirements for staff membership has been approved by the Credentials Committee, the Professional Staff Office may review each applicant according to the requirements and the job description. Those applicants meeting all requirements will be eligible for immediate authorization to provide care according to the Professional Staff Office's Affiliated Health Staff Policy.
- D.** Applicants not meeting the established job description requirements must be reviewed by Credentials Committee designees prior to being granted authorization to provide care. At any time in the Appointment process, the Credentials Committee shall have the authority to request additional information concerning the applicant.
- E.** In the situation where the Affiliate Staff member is practicing in an expanded role, authorization to provide care must be requested and granted. The decision of whether a health care worker is practicing in

¹²¹ MS.06.01.05 EP1

an expanded role is determined by the Credentials Committee. At such time that this determination is made, a protocol describing such items as minimum education requirements, training involved, experience needed, initial evaluation required, and on-going evaluation as needed must be addressed, as well as the scope and limitation of service provided. This protocol will be determined with each situation and will be approved by the sponsoring physician prior to Credentials Committee review.

- F. If an Affiliate Staff appointee was granted authorization to provide care for the purpose of assisting a particular sponsoring physician, his/her authorization shall terminate automatically upon the termination of privileges of the sponsoring physician unless s/he is reassigned to another sponsoring physician.

17.4. INITIAL APPOINTMENT/SIX (6) MONTH REVIEWS.

- A. Following initial appointment to the Affiliated Health Staff, all new members will be placed under FPPE for up to six (6) months. The Service Line Director or designee will conduct the FPPE and report the results to the Credentials Committee. Individuals who successfully complete the initial FPPE will be recommended for full appointment to the Affiliated Health Staff. If any concerns about the member's professional conduct or competence are identified during this time, the Service Line Director or designee may:
 - 1. Recommend continuation of the initial membership for up to six (6) months; or
 - 2. Advancement to full appointment, but with changes to their approved job descriptions as determined by the appropriate Service Line Director or designee, or the Credentials Committee, and accompanied by supporting documentation; or
 - 3. Complete revocation of appointment with documentation of justification by the Credentials Committee.

17.5. REAPPOINTMENT.

- A. At least annually, Affiliated Health Staff shall have a competency assessment.
- B. The Professional Staff Office shall request the staff appointee to complete the Affiliated Health Professional Staff annual assessment form. Information requested may include:
 - 1. Completed and signed job description;
 - 2. A supervising physician signed assessment;
 - 3. Continuing education activities as required for licensure;
 - 4. Health status (including drug/alcohol abuse);
 - 5. Documented licensure, registration or certification (if applicable); and,
 - 6. Adequate liability insurance (if applicable).

- C. The Staff appointee shall submit the form to the Professional Staff Office for processing. The completed form will then be submitted to the Physician Sponsor who shall evaluate the appointee, complete the Review & Assessment section of the form, and submit a recommendation for reappointment/non-reappointment and authorization to provide care to the appropriate Service Line Director or designee.
- D. The application is then reviewed by the credentialer. Complete applications and assessments meeting requirements are processed; authorization to provide care is continued and the application is presented to the Credentials Committee as meeting requirements.
- E. The Credentials Committee shall have the authority to request additional information concerning the applicant/appointee prior to the application's approval.

17.6 TEMPORARY AUTHORIZATION TO PROVIDE CARE

Temporary authorization to provide care may be granted but shall not exceed 120 days.

- A. On a case by case basis, upon recommendation of the Chief Clinical Officer or his/her designee, the CEO or his/her designee may grant temporary authorization to provide care for an important patient care need. This temporary authorization to provide care may be granted to an individual for an important patient care, treatment and service need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. This authorization requires that, at a minimum, current licensure and current competence are verified. In the absence of a complete application with verification of relevant training, experience and references, competence may be established by a written statement from the Service Line Director or designee delineating the applicant's relevant training and experience.

17.7. SUSPENSION AND TERMINATION OF AUTHORIZATION TO PROVIDE CARE.

- A. Temporary applicant's privileges shall terminate upon the first to happen of the following:
 1. The Credentials Committee takes action on the appointment and granting of clinical privileges; or
 2. Upon recommendation by the applicable Service Line Director or designee, when the application review process has not progressed to completion
- B. With or without cause, Affiliated Health Professional Staff appointee's authorization to provide care may be suspended, terminated, or subjected to conditions, by the appointee's supervising physician, the Service Line Director or designee of the service to which the

appointee has been assigned, the CEO, the Credentials Committee or the Executive Committee. However, such action may not be taken as a means of discriminating against the appointee on a prohibited basis, such as race, religion, gender, disability, or age.

- C. Affiliated Health Professional Staff members who are employees of The UAMS Medical Center, the College of Medicine or any other UAMS entity will be subject to the personnel policies of the Hospital, rather than the privileges of due process stated within these Bylaws.

ARTICLE XVIII: RULES AND REGULATIONS

18.1 The Medical Staff may adopt Rules and Regulations as may be necessary to implement these Bylaws, subject to approval by the Board of Trustees. These Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as specify the level of practice required of each member.

ARTICLE XIX: ADOPTION OF BYLAWS

19.1. The Medical Staff Bylaws of The UAMS Medical Center of Arkansas, including Rules and Regulations, shall be adopted at any regular or special meeting of the Medical Board by two-thirds vote of those present and eligible to vote. Upon adoption, the Bylaws shall replace any previous Bylaws of the Medical Staff. These Bylaws shall become effective when approved by the Board of Trustees.¹²²

ARTICLE XX: AMENDMENTS TO BYLAWS¹²³

20.1. According to “Duties of the Medical Board and Executive Committee” outlined above in Article V, the Medical Staff has delegated authority over proposing the adoption of Bylaws, Rules and Regulations and Policies and amendments thereto to the voting members of the medical staff, the Medical Board and Executive Committee. The Medical Board shall review as necessary these Bylaws Rules and Regulations and propose amendments when necessary to reflect current and future practices with respect to Medical Staff organization and functions.

20.2. These Bylaws, Rules and Regulations cannot be unilaterally amended. Approval by the Medical Board and the Board of

¹²² MS.01.01.01 EP2, EP8, EP24

¹²³ MS.01.01.01 EP8, EP9, EP10, EP24, EP25

Trustees is necessary to amend these Bylaws, Rules and Regulations. Proposed amendments shall be presented to the Medical Board at a regular or special meeting of the Medical Board where a quorum is present. An amendment shall require a two-thirds vote of members present and eligible to vote. Amendments shall become effective when approved by the Board of Trustees.¹²⁴

- 20.3** To propose changes to the Medical Staff Bylaws, Rules and Regulations or Policies, Medical Staff members must first communicate proposals to the Medical Board through the appropriate Medical Staff council or committee. If the Medical Board proposes to adopt a rule or regulation or an amendment thereto, the Medical Board will first notify the medical staff of the proposed change. Subsequently, all Medical Board approved changes to rules and regulations and policies will be communicated to the Medical Staff.
- 20.4** Any conflicts or disagreements between the Medical Staff and the Medical Board including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto, will be resolved according to the UAMS Medical Center Policy, “Conflict Management” as approved by the Board of Trustees.
- 20.5** In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the Medical Board may provisionally adopt and the Board of Trustees may provisionally approve an urgent amendment without prior notification of the Medical Staff. If this becomes necessary, the Medical Staff will have an opportunity to retrospectively review and comment on the provisional amendment. If there is no conflict submitted in writing to the Chief Clinical Officer within 5 business days of receipt of notification, the provisional amendment stands. If the stated concerns cannot be resolved through the established Medical Staff councils or committees, the issue will be addressed according to the “Conflict Management Policy”.¹²⁵

ARTICLE XXI: GOVERNING LAW

These Medical Staff Bylaws shall be governed by and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Arkansas Peer Review

¹²⁴ MS.01.01.03

¹²⁵ MS.01.01.01 EP11

Fairness Act of 2013, and to the extent not so governed, with the other laws of the State of Arkansas without giving effect to its conflict of laws principles. To the extent any provisions of the Arkansas Peer Review Fairness Act of 2013 are inconsistent with, or conflict with, the Health Care Quality Improvement Act of 1986, the provisions of the Health Care Quality Improvement Act of 1986 shall govern.¹²⁶

ARTICLE XXII: PRIVILEGES AND IMMUNITIES

Any councils or committees of the Medical Staff and/or of the Board of Trustees who conduct Professional Review Activities and any individuals within the Hospital authorized to conduct Professional Review Activities, hereby constitute themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986 and in the Arkansas Peer Review Fairness Act of 2013. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said federal and state statutes. Any action taken by a Professional Review Body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or practitioner, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

ARTICLE XXIII: BOARD OF TRUSTEES ACTIONS

The procedures specified herein shall not preclude the Board of Trustees from taking any direct action authorized under the Board of Trustees policies and/or procedures.

¹²⁶ MS.01.01.01 EP4

UAMS MEDICAL CENTER MEDICAL STAFF RULES AND REGULATIONS

- 1. APPLICABILITY:** These Rules and Regulations are adopted by the Hospital Medical Board and Board of Trustees to govern the discharge of professional services within UAMS Medical Center. These Rules and Regulations are in addition to the UAMS Medical Staff Policies and Procedures and are binding on all members.

- 2. PROVISION OF PATIENT CARE:** Medical Staff members who are in good standing may, in accordance with their clinical privileges, admit patients to the Hospital; treat inpatients and outpatients; assume responsibility for continuous care of their patients; obtain and provide consultations; and, where appropriate, provide emergency service care. Attending physicians are responsible for all medical aspects of the care of the patient.


- 3. MEDICAL STAFF HOSPITAL POLICIES:** The Medical Staff is responsible for developing and maintaining Medical Staff Hospital policies and for complying with such policies. A policy may be recommended by any Medical Board Council or Committee. All policies must be reviewed at least every two years. The Medical Board must approve all Medical Staff Hospital policies and is responsible for informing the Medical Staff when policies are implemented, revised or retired.

- 4. HOUSESTAFF:**
 - A.** Medical Staff members are directly responsible for all Housestaff patient care activities. Supervision responsibilities include, but are not limited to: reviewing and planning patient care at attending rounds; cosigning Housestaff documentation; documenting supervising physician progress notes; teaching surgical and procedural techniques; ensuring Housestaff follow Hospital policies and procedures; and remaining available for patient care consultation on a 24-hour basis.

 - B.** Each clinical service shall have specific job descriptions and/or delineated privileges for Housestaff members assigned to the service that specifies the patient care responsibilities of Housestaff members. A copy of each job description/delineated privileges shall be kept on file in the Professional Staff Office and shall be available to all staff members and Hospital employees through the UAMS Intranet.

- 5. CONTINUING EDUCATION:** Members of the Active and Courtesy Medical Staff and Advanced Practice Staff shall obtain continuing education hours annually as required by the member's licensing board and provide documentation of such at the time of each reappointment.
- 6. PROFESSIONAL CONDUCT:** Medical Staff members shall comply with the UAMS Code of Conduct, Corporate Compliance Program and Hospital and Medical Staff policies. Members are expected to conduct themselves in a professional manner in all interactions with patients, families, and Hospital personnel. Inappropriate or disruptive behavior will not be tolerated and incidents of inappropriate or disruptive behavior will be addressed in accordance with these Bylaws and applicable UAMS Policies.
- 7. RESEARCH:** Medical Staff members involved in clinical trials are responsible for assuring that the health, welfare and safety of human subjects is of primary importance. Clinical trials shall be conducted in accordance with applicable UAMS clinical policies and procedures. Individuals participating in clinical trials shall enjoy the same rights and privileges as any other UAMS patient.
- 8. REPORTING REQUIREMENTS:** Medical Staff members shall report to their Service Line Director, Department Chair, Risk Management and the Professional Staff Office all lawsuits in which they are named as defendants in their professional capacity as well as any complaints or sanctions filed against them by a regulatory, licensing or credentialing body. Such reports shall be made as soon as reasonably practicable after the member receives notice of the lawsuit/complaint.

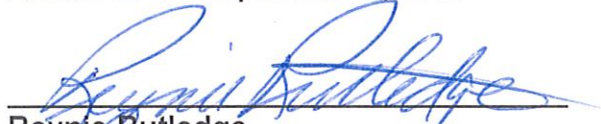
Adopted by the Medical Board of the University of Arkansas for
Medical Sciences, Medical Center on August 8, 2016



Jennifer Hunt, MD
Chairman, Department of Pathology
Chief of Staff

Date 9/19/16

Approved and upheld by the Board of Trustees of the University of
Arkansas on September 7, 2016



Reynie Rutledge
Chairman, Board of Trustees

9/8/16
Date