MEDICAL STAFF BYLAWS
RULES & REGULATIONS

UAMS MEDICAL CENTER
LITTLE ROCK, ARKANSAS

Amended November 2020

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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**" is placement into an inpatient or observation bed status by a credentialed and privileged physician (admitting physician).
2. **"Advanced Practice Registered Nurse"** as defined in the Arkansas Nurse Practice Act.
3. **"Advanced Practice Staff"** are all Advanced Practice Registered Nurses and Physician Assistants granted clinical privileges to attend patients at UAMS Medical Center.
4. **"Adverse Action"** is to reduce, restrict, suspend, revoke or deny or fail to renew clinical privileges or Medical Staff membership.
5. **"Appointees"** are all individuals appointed pursuant to these Bylaws to attend patients of UAMS Medical Center. The term appointee includes Medical Staff, Housestaff and Affiliated Health Professional Staff.
6. **"Board of Trustees"** is the Board of Trustees of the University of Arkansas.
7. **"Chancellor"** is the Chancellor of the University of Arkansas for Medical Sciences.
8. **"Chief Clinical Informatics Officer" (CCIO) is the individual responsible for all clinical data, metadata, and software utilized at UAMS Medical Center.**
9. **"Chief Clinical Officer" (CCO)** is the individual responsible for the professional activities of UAMS Medical Center.
10. **"Chief Executive Officer" (CEO)** is the individual appointed by the Chancellor to act on the Chancellor's behalf in the overall management of UAMS Medical Center.
11. **"Chief of Staff"'** is the individual elected by the Medical Staff to act, along with the Chief Clinical Officer, as the Medical Staff's chief administrative officer.
12. **"Clinical Privileges"** is the permission granted to an appointee to render specific diagnostic and therapeutic services.
13. **"Clinical Service"** is a clinical program, division or department. These may change from time to time as approved by the Hospital Medical Board.
14. **"College of Medicine"** is the UAMS College of Medicine.
15. **"Conflict of Interest"** is a personal or financial interest that would lead an objective person to conclude that it would be difficult for the person in those circumstances to make a fair and impartial decision in a Professional Review Activity with regard to a particular Medical Staff member.
16. **"Credentials Committee"** is the group of Medical Staff members defined under Article IX of these Bylaws.
17. **"Dean, College of Medicine"** is the individual appointed by the Chancellor to act on the Chancellor's behalf in the overall management of the College of Medicine.

18. **“Department Chair”** is the College of Medicine appointed head of an academic department.
19. **"Disability"** as defined in the Americans with Disabilities Act.
20. **“Due Process”** is the various procedures set forth in these Bylaws to ensure fairness when conducting Investigations or other Professional Review Activities and Actions.
21. **"Faculty Appointment"** is an appointment in the College of Medicine at the level of Instructor, Assistant Professor, Associate Professor, Professor, Distinguished Professor, University Professor or one of the above titles modified by Adjunct, Visiting or Emeritus.
22. **“Investigation”** is a formal process conducted by a Professional Review Body to obtain and make a detailed examination of facts related to an identified concern about a Medical Staff member’s professional competence or conduct in order to determine whether a Professional Review Action should be requested or recommended. The term Investigation does not include a preliminary review to obtain basic information related to a concern or complaint about a Medical Staff member to determine whether and Investigation should commence, nor does it include routine quality assurance or performance improvement activities, or collegial interventions or peer-to-peer performance improvement interventions that are not intended to and do not impact a member’s clinical privileges or Medical Staff membership.
23. **"Hospital"** is UAMS Medical Center.
24. **"Housestaff"** is 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.
25. **“Integrated Clinical Enterprise” (ICE)** is the governance and delivery system for all clinical care at UAMS Medical Center.
26. **"Medical Board"** is the group of individual Medical Staff appointees defined under Article V of the Bylaws.
27. **"Medical Center"** is UAMS Medical Center.
28. **"Medical Staff"** are all physicians, dentists and advanced practice staff granted privileges to attend patients at UAMS Medical Center.[2]
29. **“Peer Review”** is 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 Board committees. Peer review is

[2] HR.01.02.05

not an investigation for purposes of Ark. Code Ann. § 20-9-1303(4) or Ark. Code Ann. § 20-9-1301 to 20-9-1308.

30. **“Physician Assistant”** as defined in the Arkansas Medical Practices Act.
31. **“Professional Review Action”** is an action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity and that 1) 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, 2) adversely affects or may adversely affect the Medical Staff membership or clinical privileges of the Medical Staff member.
32. **“Professional Review Activity”** is an activity to: 1) determine whether an individual may have clinical privileges or Medical Staff membership; 2) determine the scope or conditions of clinical privileges or Medical Staff membership; or, 3) change or modify clinical privileges or Medical Staff membership. A Professional Review Activity includes an Investigation.
33. **“Professional Review Body”** is as appropriate to the circumstances, the Board of Trustees, the Hospital Medical Board, the Executive Committee, the Credentials Committee, any Ad Hoc Investigation Committee, any Hearing Committee, any Appellate Review Committee, the Hospital Chief Clinical Officer, the Hospital CEO, the Chief of Staff, any department, division or 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.
34. **"Reasonable accommodation"** when used in connection with a disability, will have the meaning ascribed to it in the Americans with Disabilities Act.
35. **“Service Line”** is a functional subdivision of the Integrated Clinical Enterprise (ICE), organized to enhance care delivery goals.
36. **“Service Line Director” or “Chief of Service”** is an administrator of UAMS Medical Center and the Organized Medical Staff responsible for managing medical staff functions as outlined within these Bylaws.
37. **“Summary Suspension”** is a temporary suspension or restriction of a Medical Staff member’s clinical privileges when failure to summarily suspend or restrict may result in 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.
38. **"UAMS Medical Center"** is the Hospital and all clinics and other patient care facilities where providers are privileged as part of UAMS 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

1.1. The name of the organization is the Medical Staff of UAMS Medical Center. The organized Medical Staff is accountable to the Hospital 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 committees will constitute a quorum for all actions. Except as otherwise specified herein, action on any matter will be taken by a majority vote where a quorum is present. Meetings may be attended and votes may be cast electronically when necessary.

3.2. ASSIGNMENT OF RIGHT TO VOTE. Members of the Medical Board

[3] MS.02.01.01 EP10
[4] MS.02.01.01 EP10
[5] MS.02.01.01 EP9

and Medical Board committees (with the exception of the Executive Committee) may assign their right to vote to another member of the Board or committee in which they serve or to a proxy from their Clinical Service provided that such assignment is in writing. Such assignment may be a continuing one designating another member as an alternate with right to vote in the absence of the Board or Committee member.

3.3. **RULES**. Meetings will be conducted by Robert's Rules of Order.

ARTICLE IV: CLINCAL SERVICES

4.1. **CLINICAL SERVICES ORGANIZATION.** The Medical Staff is organized into clinical services and service lines to provide patient service, education and research effectively by grouping Medical Staff administrative units.

4.2. **CLINICAL SERVICE FUNCTIONS.** Each clinical service will have the following functions:

A. Organize services to provide patient care, education and research specifically related to the 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;
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 MEMBERS OF CLINICAL SERVICE.** Each practitioner who is an Active Staff member of a clinical service will:

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 other duties as the Chief of Service or Service Line Director may assign from time to time.

4.4. CHIEF OF SERVICE AND SERVICE LINE DIRECTOR QUALIFICATIONS. A Chief of Service or Service Line Director will be appointed by the Medical Center CEO and the Dean of the College of Medicine. Chief of Service and Service Line Directors (excluding the Nursing and Pharmacy and Therapeutics Service Lines) will 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 CHIEF OF SERVICE AND SERVICE LINE DIRECTOR.[7] [8]Each Chief of Service and 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;[9]

C. Conduct all administrative and clinical functions of a clinical service including selection of a designee to act on his/her behalf for a specific specialty within their service or in his/her absence;[10]

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;[11]

E. Asses and improve the quality of care, treatment, and services and maintenance of quality control programs as appropriate for their respective service;[12]

F. Review credentials, qualifications, experience, ability and current competence of each prospective and current member and Affiliated Health Professional Staff appointees and make recommendations to the Medical Board concerning appointments, reappointments, and clinical privileges;[13]

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

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[6] MS.01.01.01 EP36
[7] MS.05.01.03 EP4,5
[8] MS.08.01.01
[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

clinical privileges and job functions relevant to the care provided by the service;[14]

H. Preside at service 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;[15]

J. Work with appropriate Medical Center 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;[16]

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;[17]

N. Assess and recommend off-site sources for needed patient care, treatment and services not provided by the Service or the Medical Center;[18]

O. Orientation and ongoing relevant education of the clinical service providers in the Department;[19] [20]

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 Dean to resolve complaints; and,

R. Lead and support activities of the Medical Board committees.

ARTICLE V: MEDICAL BOARD AND EXECUTIVE COMMITTEE [21] [22]

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

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[14] MS.01.01.01 EP36
[15] MS.01.01.01 EP36
[16] MS.01.01.01 EP36
[17] MS.01.01.01 EP36
[18] MS.01.01.01 EP36
[19] MS.08.01.03
[20] MS.01.01.01 EP36
[21] MS.02.01.01 EP1
[22] MS.01.01.01 EP20

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 Committees conduct the functions related to the Medical Staff's responsibilities.[23] [24]

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;
4. Chief Clinical Officer;
5. Chief Clinical Informatics Officer;
6. Chief Quality Officer. In the event the Chief Quality Officer is a non-physician, they will designate one physician representative from patient experience and patient safety;
7. Associate Chief Medical Quality Officer for Patient Safety when the Chief Quality Officer is a non-physician;
8. Chair of each clinical department in the College of Medicine;
9. Chief of Service or Service Line Director from each clinical service (excluding the Nursing and Pharmacy and Therapeutics Service Line);
10. Six (6) at-large members 1 of which will always be an Advanced Practice Staff member;

B. The following officials will be non-voting 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;
8. Chief Quality Officer; and,
9. Other members of the Medical Center Administration team.[25] [26] [27] [28] [29]

5.4. VACANCIES. Any membership vacancies that occur prior to the expiration of the term may be filled by an individual appointed by the

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[23] MS.02.01.01 EP5
[24] MS.02.01.01 EP10
[25] MS.02.01.01 EP4
[26] MS.02.01.01.EP2
[27] MS.4.01.01.EP5,7
[28] MS.01.01.01 EP19
[29] MS.01.01.01 EP22

Chief of Staff to serve the remainder of the term. Bylaw 6.4 addresses filling vacancies of Medical Staff officer positions.

5.5. **DUTIES.** The Medical Board will have the following duties:

A. Fulfill the Medical Staff's purposes as defined under Article II of these Bylaws;[30]

B. Represent and act on behalf of the Medical Staff, subject to limitations imposed by these Bylaws;[31]

C. Coordinate activities and general policies of various Medical Board committees and Clinical Services;

D. Receive and act upon minutes and reports from Medical Board committees and clinical services;[32]

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;[33]

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;[34] [35]

J. Enforce these Medical Staff Bylaws, Rules and Regulations and the policies and procedures of UAMS Medical Center and UAMS;

K. Appoint a committee to review and revise as indicated the Medical Staff Bylaws, Rules and Regulations every two years; submit proposed revisions to the Medical Staff for adoption and the Board of Trustees for approval;

L. Plan, organize, implement and monitor a program to grant Medical Staff appointment and reappointment, delineate clinical privileges and assign members to clinical services;[36]

M. Reasonably ensure professional and ethical conduct of every appointee; and,

N. Reasonable ensure competent clinical performance of every appointee.

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[30] MS.05.01.01 EP1,2
[31] MS.01.01.01 EP23
[32] MS.02.01.01 EP8,10,12
[33] MS.01.01.01 EP6
[34] MS.05.01.01 EP1
[35] MS.05.01.03
[36] MS.02.01.01 EP8,12

5.6. TERM OF OFFICE OF MEMBERS OF THE MEDICAL BOARD.[37] The Chiefs of Service or Service Line Directors and the non-voting members of the Medical Board will serve in an ex-officio capacity. At-large members will serve two-year terms and until a successor will be duly elected and qualified. At-large members may serve successive terms by reelection. Initial terms of at-large members may be staggered so no more than three (3) at-large members' terms will expire in the same year.

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; Chief Clinical Officer; Associate Chief Medical Quality Officer for Patient Experience; and at least three (3) at-large members appointed by the Chief of Staff.

5.8. DUTIES OF EXECUTIVE COMMITTEE. The Executive Committee will 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 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 will 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 will be kept, and will be maintained in the office of the CEO.

ARTICLE VI: ELECTION OF OFFICERS[38]

6.1. OFFICERS QUALIFICATIONS. The officers of the Medical Staff are the Chief of Staff and the Chief of Staff-Elect. Officers will be physician

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[37] MS.01.01.01 EP21
[38] MS.01.01.01 EP18,21

members of the Active 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 will be two (2) years beginning July 1 and ending June 30. The Chief of Staff-Elect will be elected in even years. The Chief of Staff-Elect, if duly elected, will 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 will 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 Clinical Officer and one (1) Hospital Medical Board At-Large Member are responsible for identifying and soliciting nominees for Medical Staff Officers and elected members of the Medical Board (including At-Large Members and the Advanced Practice Staff). In the first quarter of each year, the Nominating Committee will identify nominees for each expiring position. The subsequent ballot will be emailed to the Medical Staff using an electronic voting system. The highest number of votes received will determine the outcome. In the event of a tie, the Chief of Staff will vote to determine the outcome.

6.4. VACANCIES. Vacancies of the Medical Staff officers will be filled as follows:

A. Chief of Staff: The Chief of Staff-Elect will serve as Acting Chief of Staff for the remaining term. The Chief of Staff-Elect will then become Chief of Staff.

B. Chief of Staff-Elect: The Executive Committee will appoint one of its members who is an Active staff member to serve as the Acting Chief of Staff-Elect for the remaining term. An Acting Chief of Staff-Elect will not succeed the Chief of Staff unless elected by the Medical Staff 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.[39]

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

[39] MS.01.01.01 EP18, 21

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; or,
4. In the case of a Chief of Staff-Elect, notification of their Intention of leaving UAMS.

B. **Action of Executive Committee or Medical Board.** Removal because of termination of Active Staff membership or because of notification by a Chief of Staff-Elect of intention to leave UAMS will not require any action by the Medical Board. The Executive Committee will declare a vacancy in the office. In the case of removal for some other cause, the Chief of Staff will notify the involved officer or representative of the allegations. If the involved individual is the Chief of Staff, the Chief of Staff-Elect will notify the Chief of Staff. The officer/representative may at that point decide to resign from their position. If the officer/representative disagrees with the allegations, and wishes the Medical Board to consider the matter, the allegations against the officer/representative will be presented to the Medical Board. The officer/representative involved will 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; the right to be present at the Medical Board meeting where the allegations are presented; to confront their accuser(s) by asking them questions; and to present witnesses in their 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 will be final, and the involved officer/representative will have no appeal rights.

ARTICLE VII: DUTIES OF OFFICERS, ICE CLINICAL OFFICERS, CHIEFS OF SERVICE AND SERVICE LINE DIRECTORS[40]

7.1. CHIEF OF STAFF. The Chief of Staff will have the following duties:

A. Calls and chairs meetings of the Executive Committee, the Medical Board, the Credentials Committee and the Medical Staff;

B. Appoints Committee members; and,

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[40] MS.01.01.01 EP19

C. Addresses issues and coordinates activities of mutual concern with the Chief Clinical Officer and CEO.

7.2. CHIEF OF STAFF-ELECT. The Chief of Staff-Elect will have the following duties:

A. Acts as Chief of Staff in absence of the Chief of Staff;
B. Serves as voting member of Executive Committee; and,
C. Becomes 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) and the Chief Clinical Informatics Officer (CCIO). Both the Hospital Clinical Officers are appointed by the CEO. The CCO and CCIO 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. Assumes responsibility, in conjunction with the Chief of Staff and Chiefs of Service and Service Line Directors, for enforcing the Bylaws and the Medical Staff Rules and Regulations and for implementing sanctions where indicated;
3. Receives complaints and concerns about patient care provided by the medical staff;
4. Maintains a collaborative relationship with the Dean of the College of Medicine;
5. Supports the institutional policies on professional behavior;
6. Communicates directly with the Designated Institutional Officer (DIO) regarding graduate medical educational programs;
7. Oversees implementation of effective strategies and approaches for delivering high quality, patient- and family-centered care;
8. Shares accountability with Chiefs of Service and Service Line Directors for clinical outcomes and clinical service operations and performance;
9. Facilitates collaboration between the Medical Staff and Medical Center Administration related to management decisions and coordination of resources that impact the delivery of care;
10. Initiates Investigations;
11. Calls and chairs specially-called meetings of the Credentialing Committee related to medical staff membership and presents findings to the Hospital Medical Board when appropriate;

12. Provides oversight and direction for:
    a. Development and implementation of the patient care clinical service strategy;
    b. The advancement of patient care, education and research missions;
    c. Identifying growth opportunities in collaboration with Medical Center Administration, prioritizing resources; and,
    d. Setting performance metrics and goals by the Chiefs of Service and Service Line Directors;
13. Assists with strategic planning, execution and implementation of care management programs;
14. Under the direction of the Board of Trustees and the Hospital Medical Board, oversees the comprehensive quality assurance and performance excellence programs of the Institution;[41]
15. Works collaboratively with Chiefs of Service and Service Line Directors and Medical Center Administration to develop and measure quality, safety and performance excellence initiatives;
16. Participates in the development, monitoring, reporting and improvement of activities related to clinical pathways and guidelines;
17. Oversees patient safety, quality, infection control and risk management activities;
18. Facilitates interaction between the Medical Staff, Medical Center Administration, its governing board, and the leadership of the clinical services in order to provide effective and efficient delivery of high-quality, patient and family-centered care;
19. Provides leadership and direction for the development and implementation of institutional performance excellence initiatives;
20. Collaborates with the Chiefs of Service and Service Line Directors to assure coordination of care and effective and efficient clinical support services;
21. Works with the CCIO to ensure clinical practice quality needs are supported by the enterprise information systems; and,
22. Selects a designee to act in their absence.

B. CHIEF CLINICAL INFORMATICS OFFICER (CCIO)

1. Develops strategic plans regarding clinical systems and clinical workflows;

[41] MS.05.01.01 EP1

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 (Medical Center Administration, 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 Medical Center Administration 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;
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; and,
10. Selects a designee to act in their absence.

7.5. CHIEFS OF SERVICE AND SERVICE LINE DIRECTORS. Chiefs of Service and Service Line Directors will have the following duties:

A. Oversees the quality of medical care delivered in their respective unit, clinic or program;

B. Makes recommendations to the Credentials Committee concerning appropriate credentials necessary to perform procedures in the unit, clinic or program;

C. Works cooperatively with Medical Center Administration to determine staff levels necessary to deliver appropriate care in the unit, clinic or program;

D. Assures the operation of their unit, clinic, or program such that credentialed providers have equitable access to treat patients; and,

E. In conjunction with Medical Center Administration, determines the need for new equipment to provide expected levels of care in the unit, clinic or program.

ARTICLE VIII: MEDICAL BOARD COMMITTEES[42]

8.1. COMMITTEES. Medical Board committees have been formed to participate in discharging the duties of the Medical Board.[43] [44] The Medical Board will develop and approve a charge for each committee designating the name, membership, meeting frequency, purpose and responsibilities. The charges will be made available to Medical Staff members and practitioners with clinical privileges. The committees will meet regularly, maintain minutes and report their activities to the Medical Board. Special meetings may be called as needed by the Chair. 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 COMMITTEE MEMBERS. Committee members may be Medical Staff, other health professionals, Medical Center Administrative staff, or from the community. A majority of each committee will be members of the Medical Staff. Unless the committee charge specifies that members who are not physicians are non-voting members, they will be voting members. The Chief Clinical Officer will 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 committees unless named in the Medical Board Committee charge as a voting member. Members may concurrently serve on more than one committee.

8.3. TERM AND REMOVAL. 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 committee will provide an annual report to the Chief of Staff and the Chief Clinical Officer. The Chief of Staff may review committees for effectiveness and replace committee members as necessary. Reappointments are encouraged in order to enhance continuity. An appointment will automatically cease if a member leaves UAMS Medical Center or resigns from the committee.

8.4. VACANCIES. Any membership vacancies that occur prior to the expiration of the term may be filled by an individual appointed by the Chief of Staff to serve the remainder of the term. Medical Board approval of such appointments is not required.

8.5. DUTIES OF MEMBERS. Committee members accept responsibility to:

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[42] MS.03.01.01 EP3,4

[43] MS.03.01.01 EP1

[44] MS.05.01.01 EP1,2

A. Participate in committee functions;
B. Attend committee meetings;
C. Cooperate with committee members; and,
D. Accept voting rights.

8.6. CHAIR. The Chief of Staff will appoint a physician as the Chair of each committee. In the event of a vacancy, the Chief of Staff will 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 Staff. The Chair may delegate any duties to another committee member.

8.7. DUTIES OF THE CHAIR.

A. Schedule meetings, prepare meeting agendas and notify members of meetings;
B. Consult with the Chief of Staff on appointment of committee members;
C. Conduct the committee's business to fulfill a defined charge;
D. Record and distribute minutes including notation of meeting attendance; and,
E. Represent the committee at the Hospital Medical Board as requested.

8.8. REPORTING. Committees will have regular business meetings followed by separate quality meetings for discussion of any confidential issues that are before the committee. Each committee will keep a record of its minutes and attendance roster. Separate minutes will be kept for the quality meetings. Minutes will be approved by the membership and signed by the committee chair. Business and quality minutes will be maintained in the office of the Chief of Staff or their delegate, in the administrative offices of ICE. Committees will 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.[45]

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.

[45] MS.05.01.01 EP3

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 reappointment requests and associated documentation; 2) Assess 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 Identified Concerns about Professional Competence or Conduct**: 1) Oversee Investigations; 2) Review Investigation findings; and, 3) Recommend Professional Review Actions when necessary.
4. **On a perpetual basis: Review and revise** Departmental privilege lists as necessary and make recommendations concerning privileging processes for specific procedures.[46]

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

ARTICLE X: MEDICAL STAFF RESPONSIBILITIES AND CATEGORIES

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 in the medical profession at UAMS Medical Center by virtue of Medical Staff appointment will 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.

[46] MS.02.01.01 EP10

10.2. RESPONSIBILITIES OF APPOINTMENT.[47] [48] By applying for and accepting a Medical Staff appointment, the applicant has agreed to:

- **A.** Abide by Medical Staff Bylaws, Rules and Regulations, and policies;[49]
- **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 their patients, 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 including, but not limited to, investigations and hearing;
- **M.** Participate in continuing education;[50]
- **N.** Participate in and cooperate with quality assurance, quality improvement, and utilization review activities;[51] [52]
- **O.** Provide continuity of patient care;
- **P.** Accept voting rights;[53]

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[47] MS.03.01.03
[48] MS.01.01.01 EP15
[49] MS.01.01.01 EP5
[50] MS.12.01.01
[51] MS.05.01.01
[52] MS.05.01.03 EP2
[53] MS.01.01.01 EP17

Q. Complete and document medical histories and physical examinations as follows:[54] [55]

1. A medical history and physical examination and any updates regarding same must be completed and documented by a member of the Active or Courtesy Staff, Advanced Practice Staff or Housestaff in accordance with hospital policy and state law;
2. A medical history and physical examination must be completed within the first twenty-four (24) hours after admission to inpatient or observation services. If the patient requires surgery or a procedure requiring anesthesia services, it must be done prior to the procedure except in the event of a medical or surgical emergency;
3. The medical history and physical examination may be completed up to thirty (30) days before a scheduled admission to inpatient or observation services. The examination must be updated for any changes in the patient's condition within twenty-four (24) hours after admission or registration and prior to surgery or a procedure requiring anesthesia services;

R. Abide by UAMS Medical Center Policies and Procedures;[56]

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;
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;
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; and,

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[54] MS.03.01.01 EP6,8,9,10

[55] MS.01.01.01 EP16

[56] MS.01.01.01 EP5,6

6. If board certification expires, is allowed to lapse, 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 will consist of Active, Courtesy, Honorary and Advanced Practice Staff categories.[57] [58] 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 STAFF. The Active Staff will 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. All members of the Active Staff will hold a faculty appointment in the College of Medicine; will be assigned to a Clinical Service and will have delineated clinical privileges. Active Staff members will be eligible to serve on Medical Board committees.

10.5. COURTESY STAFF. The Courtesy Staff will consist of physicians or dentists duly licensed in Arkansas who may occasionally treat patients at the Medical Center or act as consultants. Appointment to the faculty in the College of Medicine does not assure membership to the Medical Staff. All members of the Courtesy Staff will hold a faculty appointment in the College of Medicine; will be assigned to a Clinical Service and will have delineated clinical privileges. Courtesy Staff appointed to committees may serve as voting members.

10.6. HONORARY STAFF. The Honorary Staff will consist of any physician with purely administrative roles or physicians and dentists who are not active in the Medical Center but are honored by emeritus positions. Honorary Staff membership in an administrative role may be granted upon the Chief Clinical Officer’s invitation and emeritus positions may be granted upon the applicable Chief of Service or Service Line Director’s invitation to the respective member. Honorary Staff members in an emeritus position will be assigned to a clinical service, but will not have any clinical privileges other than such consulting privileges as may be delineated. All Honorary Staff will be eligible for membership and have the right to vote on Medical Board committees. If they have privileges to do so, they may render consultative care for patients. Attendance at clinical service and annual staff meetings will not be required. To the extent necessary for them to exercise any

[57] MS.01.01.01 EP12,15
[58] MS.01.01.01 EP22

consultative privileges they may have, Honorary Staff members will 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 nor the professional malpractice liability requirement. 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 will consist of the individuals licensed in Arkansas as either Advanced Practice Registered Nurses (APRNs) or as Physician Assistants (PAs). The Advanced Practice Staff must be employed by UAMS Medical Center, 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 Staff of UAMS Medical Center.[59] 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 committees and may vote if so designated in the committee charge.[60]

ARTICLE XI: MEDICAL STAFF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES APPLICATION[61] [62] [63] [64]

11.1. GENERAL.[65] [66] All applications for Medical Staff appointment, reappointment, and clinical privileges will 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 will 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

[59] MS.01.01.01 EP17
[60] HR.01.02.05
[61] MS.01.01.01 EP13,27
[62] MS.06.01.03 EP 1,4
[63] MS.06.01.05 EP2,3,4,5
[64] MS.07.01.01 EP1,2
[65] MS.06.01.03. EP2,3
[66] MS.06.01.05

implemented by the Professional Staff Office to support and enforce these Bylaws.[67]

11.2. ELIGIBILITY. To be eligible for appointment to the Medical Staff an applicant will be: [68]

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 UAMS Medical Center privileged Medical Staff physician;

D. A United States citizen or a person with an appropriate visa;

E. For appointment to the Active Staff or Courtesy Staff;

1. The applicant will also have successfully completed an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), Commission on Dental Accreditation (CODA) or other 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,

b. if unable to meet the requirements of Section 11.2.E.1.a. because the applicant is not eligible for board certification in their cognate specialty, has received a waiver of the board certification requirement from the sponsoring Department Chair, appropriate Chief of Service or Service Line Director and Chief Clinical Officer after providing evidence of satisfactory alternative education and training to support the position and clinical privileges for which the applicant is applying;

2. Individuals may be granted Active or Courtesy Staff membership while in preparation for board certification. Such members are required to achieve board certification within a maximum of seven years following successful completion of accredited training plus time (if any) in practice required by the board for admissibility to the certifying exam. The Credentials Committee may extend such a status of an additional period of one (1) year for good cause.

3. Members initially appointed to the Medical Staff prior to July 1, 2002 who were not board certified at the time of initial appointment and who have held full and unrestricted clinical

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[67] MS.06.01.09 EP4

[68] HR.01.02.05

privileges since their initial appointment will not be required to hold board certification.

4. Members initially appointed to the Active or Courtesy Staff between July 2, 2002 and December 31, 2016, who are not board certified but have completed the requirements to become eligible to sit for their board certification examination will be required to obtain board certification or a waiver by December 31, 2018.

F. For appointment to the Advanced Practice Staff, the applicant will also be certified or in preparation for certification by a certifying body approved by the Arkansas State Board of Nursing for licensure or the National Commission on Certification of Physician Assistants (NCCPA).

11.3. APPLICATION REQUIREMENTS. A completed application includes the following:

A. Appropriate signed and dated application;
B. All requested information;
C. All requested attachments;
D. Completed and approved privilege forms;
E. Prescriptive protocols (when applicable); and, `
F. An Arkansas State Medical Board CCVS profile for physicians.

11.4. SUBMISSION OF APPLICATION. Submission of the application signifies the applicant's:

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 will 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, settlement of a potential professional liability action, sanctions or adverse actions against the applicant.

11.5. REVIEW PROCESS.[69] [70] [71] [72]

A. Application Submission to the Professional Staff Office (PSO). Applications for initial appointment, reappointment, and clinical privileges will be submitted to the Professional Staff Office which will review the application for completeness, determine eligibility and perform primary source verification of all critical data elements. Reasonable efforts will 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 will be notified, and will be responsible for completing and resubmitting the application. The PSO will not continue the review process if the applicant does not meet eligibility requirements or until the application is complete. Failure to cure an incomplete application within three (3) months of receipt of notice will be deemed a voluntary withdraw 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, Initial FPPE and requested changes in privileges and

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[69] MS.01.01.01 EP14
[70] MS.06.01.05 EP11
[71] MS.06.01.07 EP1,2,4,5
[72] MS.07.01.01 EP5

makes a recommendation concerning requested privileges to the Medical Board. If the Credentials Committee raises a concern or complaint about the professional competence or conduct of an applicant/member during the application review, an Investigation will 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 the Credentials Committee's recommendation on each application and may review any associated documentation. The Medical Board 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 will 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 will be referred back to the Medical Board for further action consistent with the Board of Trustees decision.[73]

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 application/member, the individual will be notified in writing of the hearing and appeal rights set forth in Article XIV.

11.6. ELEMENTS CONSIDERED IN APPLICATION.[74] [75] During the application review process, the following elements will 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:[76]

1. Current licensure, DEA certification (if applicable). Any challenges to licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration;[77]
2. File with National Practitioner Data Bank;[78]

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[73] MS.06.01.07 EP8
[74] MS.06.01.07 EP1,2,6,7
[75] HR.01.02.05
[76] MS.06.01.05 EP1,8,9
[77] MS.06.01.03 EP6
[78] MS.06.01.05 EP7

3. Training relevant to the specific practice;[79]
4. Certification status with the applicable specialty board;
    a. For APRN appointments to the Advanced Practice Staff: applicants will 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 will 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 will not be required to hold certification;
5. Current professional, competence, performance, experience and ability;[80]
6. Quality assurance, quality improvement, and utilization review participation;
7. Evidence of physical ability to perform the requested privileges;[81]
8. Health status (including, but not limited to, substance abuse, medical or psychiatric disorders);[82]
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;[83]
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;

[79] MS.06.01.03 EP6
[80] MS.06.01.03 EP6
[81] MS.06.01.05 EP6
[82] MS.06.01.05 EP6
[83] MS.07.01.03 EP1

17. Malpractice claims and lawsuits alleging medical injury;
18. Copy of an acceptable picture ID;[84]
19. A statement explaining any voluntary or involuntary termination of Medical Staff membership;
20. A statement explaining any voluntary or involuntary limitation, reduction, or loss of clinical privileges;
21. If available, data from professional practice review by an organization that currently privileges the applicant; and,
22. 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 will 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 origin are not used in making decisions regarding clinical privileges.[85] [86]

11.7. INITIAL APPOINTMENT/INITIAL FPPE.[87]

A. Following initial appointment to the Medical Staff and granting of clinical privileges, all new members will undergo an Initial FPPE. The Chief of Service or Service Line Director will conduct the FPPE and report the results to the Credentials Committee within the first six (6) months of appointment;

B. Individuals must successfully complete the initial FPPE to 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 Chief of Service or Service Line Director will refer the matter to the Chief Clinical Officer to determine if an Investigation or other Professional Review Activity is warranted pursuant to Article XIII.

[84] MS.06.01.03 EP5
[85] MS.06.01.07 EP3
[86] MS.07.01.01 EP4
[87] MS.08.01.01 EP1

11.8. REAPPOINTMENT.[88] [89]

A. General: The effective period of an appointment will not exceed a two year period. At this time the appointee is eligible for reappointment;[90]

B. Criteria for Reappointment:[91] Recommendations for reappointment and clinical privileges delineation will be based on the following criteria:[92]

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;[93]
- **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 and ongoing professional practice evaluations;[94]
- **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 they have a disability, an evaluation of reasonable accommodations for such Medical Staff member will be made (but no discrimination will 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;

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[88] MS.07.01.01 EP3
[89] MS.01.01.01 EP14
[90] MS.06.01.07 EP9
[91] MS.06.01.05 EP8,9
[92] HR.01.02.05
[93] MS.06.01.05 EP7
[94] MS.08.01.03

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; and
t. Collaborative agreements (APRNs), practice agreements (PAs) and prescriptive protocols as required by licensure and hospital policy.

2. Attendance at Medical Staff meetings and clinical service meetings;
3. Attestation of continuing medical education obtained annually as required by the member's licensing board;
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; and
8. Service and attendance on Medical Board committees.

D. Application for Reappointment**;**

1. Approximately six months prior to expiration of the privilege effective period, the Professional Staff Office will request the staff member to complete a Reappointment Application. Members will return the completed form to the Professional Staff Office no later than 14 days after it is sent to them. Information requested (from the applicant) includes:
   a. Completed privilege request forms. New privilege requests will include justification documentation;
   b. Attestation of Continuing Medical Education hours obtained annually as required by the member's licensing board;
   c. If the member has identified a disability, an evaluation of reasonable accommodations for such person will be made (but no discrimination will 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;[95]
   e. Canceled or refused professional liability insurance coverage;
   f. Health status (including, but not limited to, substance abuse, medical or psychiatric disorders);

[95] MS.06.01.05 EP1

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, will also request reports from the National Practitioner Data Bank, the Arkansas State Medical Board, and from UAMS's Quality Management Department, and will seek such information from other sources as the CEO deems related to the reappointment application;
3. Applicants for reappointment will be presented to the Credentials Committee, 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 will 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 will forward the completed application packet to the Chiefs of Service and Service Line Directors when credentialing is complete and at least 14 days prior to the Credentials Committee. The Chiefs of Service and Service Line Directors 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 will communicate approved privileges to the hospital staff within two (2) business days of the granting of the privileges; and,[96]
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.[97] [98]

A. Medical Staff members will 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 will be entitled to exercise only those clinical privileges specifically granted to such member. Each Chief of Service and Service Line Director will have the responsibility to continually monitor and assure that all Medical Staff members with clinical privileges within the respective service will provide only those services within the scope of privileges granted. The Medical Board will have responsibility to assure the provision of the same level of quality patient care by all individuals with delineated clinical privileges within

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[96] MS.06.01.09 EP3
[97] MS.06.01.05 EP10,12
[98] MS.01.01.01 EP15

and across clinical services and among all Medical Staff members. The Medical Board will conduct this responsibility through the established quality assurance program;

D. All Active or Courtesy 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 Staff members will only have the privileges which have been specifically delineated for a particular Honorary Staff member, and in no event will 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 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 will determine which clinical services can be provided by telemedicine;

G. Every patient will be under the care of a member of the Active or Courtesy Staff. The responsibility cannot be delegated to any person who is not a member of the Active or Courtesy Staff; and,

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 Chief of Service or Service Line Director 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.[99] Temporary Privileges may be granted but will not exceed 120 days. Upon recommendation of the Chief Clinical Officer, the CEO or their designees may grant the following temporary privileges.[100]

A. Temporary Privileges Granted for an Important Patient Care Need (Urgent Privileges).[101] On a case by case basis, temporary privileges

[99] MS.06.01.13 EP1

[100] MS.06.01.13 EP4,5,6

[101] MS.06.01.13 EP2

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, receipt of complete application as defined in Section 11.3. and current licensure, current professional liability coverage and current competence are verified. In the absence of a complete file with verification of relevant training, experience and references, competence may be established by a written statement from the Chief of Service or Service Line Director delineating the applicant's relevant training and experience;

B. Temporary Privileges Granted for New Applicants.[102] [103] 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 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 Chief of Service or Service Line Director by the CEO following review and approval by the Chief Clinical Officer as the designee of the Chief of Staff. Practitioners with visiting privileges will practice under the direct supervision of the appropriate Chief of Service or Service Line Director or their designee. They will not have admitting privileges. Such privileges will 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 of up to one year. The Medical Board will 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 will continue to be a Medical Staff member with full clinical

[102] MS.06.01.13 EP3
[103] MS.06.01.11

privileges. If the time for reappointment occurs during the leave of absence, the member may defer the reappointment process until their return from leave of absence;

B. The reappointment process for a member who has been on a leave of absence will 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 will automatically terminate unless an extension is granted by the Medical Board. If the individual wishes to return to the Medical Staff, they must complete the procedure for initial appointment.

11.12. CHANGE IN PRIVILEGES.[104] Members requesting revisions to clinical privileges must submit documentation from their Chief of Service or Service Line Director supporting 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 and verify current licensure in conjunction with the request.

11.13. DISASTER PRIVILEGES. [105] 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 their designee, the Chief of Staff, or the Chief Clinical Officer, 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 the grantor's 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 organization or group;

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);

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[104] MS.06.01.05 EP7

[105] EM.02.02.13

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 member of the Active or Courtesy Staff. It will be the priority of the Professional Staff Office to immediately begin the credentialing process of providers receiving disaster privileges and to 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 seventy-two (72) hours (if possible) from the time the volunteer practitioner presented to the organization. In the extraordinary event that verification cannot be completed in seventy-two (72) hours, it will be done as soon as possible.

Within seventy-two (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 ADMINISTRATIVE SUSPENSION[106] [107] [108]

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 a Professional Review Action and is not subject to hearing or appeal. Termination of a Member's clinical privileges and Medical Staff appointment will automatically occur under the following circumstances:

A. Permanent loss or revocation of license to practice;

B. Permanent loss or revocation of DEA certificate;

[106] MS.01.01.01 EP28

[107] MS.02.01.01 EP6

[108] MS.01.01.01 EP30

C. Failure to achieve board certification within the time limits prescribed by these Bylaws or being found ineligible for further preparation for board certification;

D. 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 unless the Credentials Committee has granted a waiver of this requirement;

E. Involuntary exclusion from participation in Medicare, Medicaid or other federally funded health care programs;

F. Termination of the Member's faculty appointment in the College of Medicine;

G. Conviction of a felony;

H. 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; or,

I. Failure to cure an Administrative Suspension within ninety (90) days' of receiving notice of the suspension.

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

12.2. ADMINISTRATIVE SUSPENSION. [109] The following will result in administrative suspension of Medical Staff membership and/or clinical privileges until the reason for the suspension is cured:

A. In the event a Medical Staff member's license authorizing practice in this State is suspended or restricted, the action and its terms will automatically apply to Medical Staff membership and/or clinical privileges as appropriate. Such an action by the State Medical Board may trigger an Investigation pursuant to Section 13.5. 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 suspended, stayed, or restricted, the action and its terms will automatically apply to the member's right to prescribe, dispense or administer medications covered by the certificate until there is evidence of certificate of renewal. Such an action by the DEA may trigger an Investigation pursuant to Section 13.5. If a Medical Staff member's

[109] MS.01.01.01 EP31

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 renewal;

C. Failure to comply with medical record documentation requirements as further described in the Delinquent Medical Record Policy, ML.2.06;

D. Failure to maintain professional liability insurance as required by these Bylaws. Failure to provide such evidence within three (3) months of the date of suspension will be deemed a voluntary resignation from the Medical Staff; or,

E. Administrative suspensions will be reported to the appropriate Department Chair, Chief of Service or Service Line Director and Credentials Committee. Medical Staff members who have repeated administrative suspensions are subject to disciplinary action in accordance with UAMS employment policies.

Administrative suspension of a membership or clinical privileges under this Section is not a Professional Review Action and is not subject to hearing or appeal. Medical Staff members on leave of absence are not subject to automatic suspension during their leave period, but must meet all applicable eligibility requirements prior to returning to practice.

12.3. **PATIENT REASSIGNMENT.** If an automatic termination or administrative suspension result 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 Chief of Service or Service Line Director 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 REVIEW ACTION[110] [111]

13.1. BASIS FOR PROFESSIONAL REVIEW ACTION.[112] The Medical Staff Organization is responsible for conducting Professional Review Activities whenever it appears that the competence or professional conduct of any applicant/appointee:

A. Jeopardizes, or may jeopardize, the safety or best interest, quality of care, treatment or services to the 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

[110] MS.01.01.01 EP33
[111] MS.09.01.01
[112] MS.01.01.01 EP30

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. TYPES OF PROFESSIONAL REVIEW ACTIONS.[113]

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 longer than thirty (30) days;

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 specific conditions or requirements are met or until required education, training or remediation is completed;

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 letter or reprimand, probation, suspension, or termination for an employment issue unrelated to competence or professional conduct;

3. Automatic termination or administrative suspension under Sections 12.1 or 12.2;

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[113] 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; or,
5. Alternatives to Professional Review Actions that are not intended to, and do not, impact a member's clinical privileges or Medical Staff Membership include, but are not limited to:
   a. Informal discussions or formal meetings regarding concerns raised about conduct or performance;
   b. Written letters of guidance, reprimand or warning regarding concerns about conduct or performance;
   c. Notification that future conduct will be closely monitored and notification of expectations for improvement;
   d. Recommendations for seeking continuing education, consultations, or other assistance in improving conduct or interactions with others; or,
   e. Warnings regarding potential consequences of failure to improve conduct or performance.

13.3. SUMMARY SUSPENSION.[114] [115] [116]

A. The Executive Committee or any two of the following individuals will have the authority to summarily suspend 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 Chief of Service or Service Line Director, the Chief Clinical Officer or the Department Chair of the Department to which the provider reports. Such Summary Suspension will become effective immediately upon imposition and written notice of suspension will be provided to the member as soon as possible;

B. The Chief Clinical Officer will be immediately notified any time a Summary Suspension is imposed. A Summary Suspension imposed by individuals other than the Executive Committee will be reviewed by the Chief Clinical Officer and at least two members of the Executive Committee to determine whether the suspension will be continued, modified or voided. If the suspension is continued or modified, an Investigation will be initiated 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.

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[114] MS.01.01.01 EP29
[115] MS.01.01.01 EP31
[116] MS.01.01.01 EP32

13.4. PATIENT REASSIGNMENT. If a Summary 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 Chief of Service or Service Line Director 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.

13.5. INVESTIGATIONS.

A. A request for an Investigation to review the competence or professional conduct 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;

B. Requests must be submitted to the Chief Clinical Officer who will review the request in consultation with the Chief of Staff to determine whether an Investigation is warranted. If an Investigation is initiated, the affected individual will be notified in writing within five (5) business days. Imposition of a Summary Suspension will trigger an Investigation;

C. The Chief Clinical Officer will assign a peer or peer group to perform the Investigation. Any assigned peer group will be comprised of no more than two (2) members of the Credentialing Committee. In the event no appropriate peer or peer group is available and it is necessary to select an external reviewer to perform the Investigation, such reviewer will be selected in accordance with the Arkansas Peer Review Fairness Act, as amended;

D. The Investigation may be performed through a focused professional practice evaluation or other appropriate process and will be completed as expeditiously as possible. The Investigation may include a review of all relevant records and reports and interviews with the affected individual and individuals having relevant knowledge of the matters considered. Any interviews will be conducted without attendance of counsel, and a summary of the interview will be prepared by the interviewers. Procedural rules for a formal hearing will not apply to an Investigation;

E. A written report of the Investigation findings, which will include all relevant information reviewed will be prepared and a copy provided to the affected individual and the Credentials Committee;

F. During a specially called Credentials Committee meeting chaired by the Chief Clinical Officer, the Credentials Committee will review the Investigation findings as soon as practical after the conclusion of the Investigation; The affected individual will be given the opportunity to discuss the findings with the Credentials Committee before a recommendation is made;

G. The Credentials Committee may (1) close the matter if there are no findings to substantiate the concern, (2) initiate a corrective action, or (3) recommend a Professional Review Action; and,

H. The Credentials Committee, via the Chief Clinical Officer, will report any Professional Review Action recommendation to the Hospital Medical Board.

13.6. PROFESSIONAL REVIEW ACTIONS.

A. The Hospital Medical Board will review the Investigation findings and recommendation of the Credentials Committee and determine whether to close the matter, impose corrective action, or propose a Professional Review Action;

B. The Chief Clinical Officer will present the recommendation of the Credentials Committee to the Hospital Medical Board;

C. The affected individual will be given the opportunity to discuss the recommendation with the Hospital Medical Board before a Professional Review Action is proposed;

D. Whenever the Hospital Medical Board proposes a Professional Review Action, the affected individual will 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 within five (5) business days after the decision is made. A copy of the notice will also be sent to the Chief of Staff, respective Department Chair, Chief of Service or Service Line Director and Dean of the College of Medicine;[117]

E. All Professional Review Actions proposed by the Hospital Medical Board will be communicated to the Board of Trustees in writing for approval. No final action will be taken until the affected individual has waived or exhausted their hearing and appeal rights pursuant to Article XIV;

F. A Professional Review Action must state a procedure for concluding the Action; and,

G. Professional Review Actions will be reported to the Arkansas State Medical Board and the National Practitioner Data Bank as required or allowed by law.

13.7 ATTORNEYS

At any stage of the procedure outlined in Article XIII, when an attorney is participating on behalf of UAMS Medical Center and the affected individual is present, they will also be permitted to have independent legal counsel participating in the activity.[118]

ARTICLE XIV: HEARING AND APPEAL[119] [120]

[117] MS.06.01.09 EP5

[118] Ark. Code Ann. § 20-9-1304(b)

[119] MS.01.01.01 EP34

[120] MS.10.01.01

14.1. GROUNDS FOR HEARING. Any proposed Professional Review Action that adversely affects a member's clinical privileges or medical staff membership will constitute grounds for a hearing.

14.2. REQUESTS FOR HEARING.[121] [122]

A. A petitioner has 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 constitutes voluntary waiver of any hearing rights and acceptance of the decision. Upon expiration of thirty (30) days, the decision will be forwarded to the Board of Trustees and will be immediately effective and final;

B. Upon receipt of a request for a hearing, the Chief of Staff will appoint an ad hoc hearing panel and schedule a hearing within thirty (30) calendar days from the date of the request, unless both the Chief of Staff and the petitioner agreed to a later date. Notice will be given to the petitioner of the time, place and date for the hearing; and,

C. The petitioner may request postponements of time beyond the times expressly permitted in these Bylaws and such postponements will be permitted by the Chief of Staff or hearing panel on a showing of good cause.

14.3. HEARING PANEL SELECTION.[123] [124]

A. The hearing panel will consist of five (5) members of the Active Staff. A third party Hearing Officer or Arbitrator will not be used;

B. 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 will not be chosen to serve on the hearing panel;

C. The Chief Clinical Officer will prepare a list of potential panel members and provide the list to the petitioner. The petitioner will be given five (5) business days to submit a written objection to any member based on a potential conflict of interest;

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[121] MS.10.01.01 EP2

[122] MS.10.01.01 EP3,4

[123] Ark. Code Ann. Section 20-9-1309

[124] MS.01.01.01 EP35

D. Individuals selected to serve on the panel will disclose any potential unresolved personal, professional or financial conflicts of interest with the petitioner to the Chief Clinical Officer who will consider all disclosures and objections and make a final determination of whether a conflict exists and who will serve on the panel;

E. If the petitioner objects to an individual chosen to serve on the panel, the Chief Clinical Officer will assess the validity of the objection and document the reason for determining whether a conflict exists;

F. The Chief Clinical Officer will appoint one member of the hearing panel to serve as Chairperson. Decisions will be made by a majority of the members; and,

G. Panel members must agree to exercise unbiased, independent and professional judgement when evaluating the competence or professional conduct of the petitioner.

14.4. CONDUCT OF HEARING.

A. No later than twenty (20) business days prior to the hearing, theChief of Staff (on behalf of the Hospital Medical Board) and the petitioner will disclose all relevant information related to the hearing to each other whether via formal or informal discovery.

B. The Chief of Staff and petitioner will provide each other with a list of witnesses expected to testify and documents expected to be introduced at the hearing at least ten (10) business days prior to the commencement of the hearing;

C. It will be the duty of the petitioner and the Chief of Staff 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;

D. Any hearing held pursuant to these Bylaws is for the purpose of intra-professional resolution of matters bearing on professional conduct or competence. Relevant evidence, including hearsay, will be admitted regardless of admissibility in a court of law. The Chair of the hearing panel will 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 panel; and, 4) generally advise the panel on the discharge of its functions;

E. 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;

F. Both the Professional Review Body and the petitioner have the right to representation by an attorney or other person at the hearing. The Chair of the Professional Review Body will either represent or designate a member of the Body to represent the Body at the hearing.

Each party will 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. Each member of the Professional Review Body is not required to be present at the hearing;

G. The Professional Review Body must present evidence supporting its proposed action and the petitioner will bear the burden of persuading the hearing panel by the substantial weight of evidence provided at the hearing that the decision of the Professional Review Body was not supported by substantial evidence;

H. Any dispute over relevance or the method of discovery, or any other dispute that arises during the hearing process will be resolved by the hearing panel;

I. Upon receipt of all evidence and argument, the hearing will be closed; and,

J. Failure of the petitioner to appear without good cause at a hearing constitutes voluntary waiver of any hearing rights and acceptance of the decision. In the event of voluntary waiver, the decision of the Hospital Medical Board will be forwarded to the Board of Trustees and will be immediately effective and final.

14.5. ACTION OF HEARING PANEL. The hearing panel will conduct deliberations and render a final written decision based on the record produced at the hearing within thirty (30) days. The decision will include a statement identifying the basis for the decision and findings of fact supporting the decision on each matter contained in the notice of action. The decision will be delivered to the petitioner, Chief of Staff, Professional Review Body and Board of Trustees. The decision of the hearing panel may be appealed as provided in Section 14.6.

14.6. APPEAL OF PROFESSIONAL REVIEW ACTION.[125]

A. Whenever a decision of the hearing panel is adverse to the petitioner, the petitioner may appeal the decision to the Board of Trustees. No petitioner is entitled to more than one evidentiary hearing and appellate review of 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 only permissible grounds for an appeal of the hearing panel decision are: 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 will 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

[125] MS.10.01.01 EP5

the review. The date of appellate review will not be less than fifteen (15) nor more than ninety (90) calendar 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) of its members;

E. The proceedings on appeal will be based on the hearing panel record. The appeal board may accept additional evidence subject to a showing that such evidence could not have been made available to the hearing panel 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 will be the decision of the Board of Trustees. The Board of Trustees may affirm, modify or reverse the decision of the hearing panel or remand the matter for further review and recommendation within a time frame determined by the Board. The decision of the Board of Trustees will be immediately effective, final, and not subject to further hearing or appeal; and,

G. Written notice of the final decision will be provided to the petitioner and Chief of Staff to be presented to the Hospital Medical Board. Copies of the decision will also be sent to the respective Chief of Service or Service Line Director and Department Chair, Dean of the College of Medicine and Professional Staff Office.

ARTICLE XV: HOUSESTAFF

15.1. HOUSESTAFF[126]

A. The "housestaff' consists 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.

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[126] MS.04.01.01 EP1

B. The housestaff are eligible to serve on 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 Staff members as defined in the Medical Staff Bylaws and are not voting members of the Medical Staff;[127]

C. The Chief of Service and Service Line Directors are responsible for ensuring that each housestaff member is supervised by a member of the Active or Courtesy Staff within their service. The Chief of Service or Service Line Director will establish patient care activities consistent with ACGME guidelines that can be carried out by housestaff. Within such parameters, members of the Active or Courtesy Staff may delegate certain duties and responsibilities according to the individual housestaff member's capabilities and experience. Members of the Active and Courtesy 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 Staff member. The housestaff are directly responsible to upper level housestaff and assigned to Active or Courtesy Staff members, as well as to their respective Chief of Service or Service Line Director to the Chief of Staff, and to the Chief Clinical Officer for clinical aspects of patient care and pertinent UAMS Medical Center policies; and,

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 MEETINGS

16.1. The Medical Staff will hold an annual meeting and meet as deemed appropriate by the Chief of Staff. The Chief of Staff will preside.

ARTICLE XVII: AFFILIATED HEALTH PROFESSIONAL STAFF[128]

17.1. GENERAL

A. Affiliated Health Professional Staff appointees will be health professionals: 1) who hold health care related advanced degrees or have a proven skill in the area of their specialty; 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; and, 3) are employed by UAMS;

B. The Affiliated Health Professional Staff is a separate staff from the Medical Staff. Affiliated Health Professional Staff appointees are not

[127] MS.01.01.01 EP17

[128] MS.01.01.01 EP26

members of the Medical Staff, and no Affiliated Health Professional Staff appointee will be eligible to hold office or vote as a Medical Staff member;[129]

C. Affiliated Health Professional Staff appointees will not have admitting privileges, and will 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 their area of competence;
3. Perform services within their area of professional qualification, competence and according to their approved job description; and,
4. Record reports and progress notes in the patient's record;

D. Affiliated Health Professional Staff appointees will attend regularly scheduled meetings of the clinical service to which they are assigned;

E. The Affiliated Health Professional Staff is divided into Consulting Scientists and Allied Health Personnel;

F. Each Affiliated Health Professional Staff appointee will have a "sponsoring physician" who will be a member of the Active or Courtesy Staff. In the case of Consulting Scientists, the sponsoring physician will ordinarily be the Chief of Service or Service Line Director to which the Consulting Scientist is assigned. In the case of Allied Health Personnel, the sponsoring physician may be the Service Line Director to which the Consulting Scientist is assigned. In the case of Allied Health Personnel, the sponsoring physician may be the Chief of Service or Service Line Director or the physician who is directly responsible for their supervision; and,

G. Each Affiliated Health Professional will be assigned to a clinical service and will be authorized to provide care with definitive lines and level of supervision delineated in writing. Authorization to provide care may be granted to Affiliated Health Professional Staff and will be consistent with their profession, licensure, experience and competence.

17.2. CATEGORIES. Affiliated Health Professional Staff will 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. Department of Education. While they may not admit patients, Consulting Scientists may be authorized to consult in relation to patients when their

[129] MS.01.01.01 EP17

special consulting scientist skills may be useful and in activities of education and research;

B. ALLIED HEALTH PERSONNEL. Allied Health Personnel will 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 will make application for initial appointment, reappointment and authorization to provide care. This application will be submitted to the Professional Staff Office.Acting on behalf of the CEO, the PSO will
review the application for completeness and verify the accuracy of the data provided. The complete application will consist of:

1. An application completed and signed by the applicant;
2. Verified current Arkansas licensure/certification, if applicable;[130]
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 will 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 their 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 will review each applicant according to the requirements and the job description. Those applicants meeting all

[130] MS.06.01.05 EP1

requirements will be eligible for immediate authorization to provide care according to the Professional Staff Office's Affiliated Health Provider Policy;

D. Applicants not meeting the established job description requirements must be reviewed by the Credentials Committee prior to being granted authorization to provide care. At any time in the Appointment process, the Credentials Committee will have the authority to request additional information concerning the applicant;

E. If an Affiliated Health Professional Staff member seeks to practice in an expanded role, authorization to provide care must be requested and granted. The decision of whether a health care worker may practice in an expanded role is made by the Credentials Committee.If approved, a protocol must describe minimum education requirements, training involved, experience needed, initial evaluation required, on-going evaluation, and the scope and limitation of service requested. This protocol will be determined on a case-by-case basis and must be approved by the sponsoring physician prior to Credentials Committee review; and,

F. If an Affiliated Health Professional Staff appointee was granted authorization to provide care for the purpose of assisting a particular sponsoring physician, their authorization will terminate automatically upon the termination of privileges of the sponsoring physician unless they are reassigned to another sponsoring physician.

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

A. Following initial appointment to the Affiliated Health Professional Staff, all new members will undergo a six (6) month review. The Chief of Service or Service Line Director will conduct the six (6) month review and report the results to the Credentials Committee within the first six (6) months of appointment;

B. Individuals must successfully complete the six (6) month review to be recommended for full appointment to the Affiliated Health Professional Staff. Recommendations will be presented to the Hospital Medical Board for approval and to the Board of Trustees for final approval; and,

C. If any concerns about the member's professional conduct or competence are identified during this time, the Chief of Service or Service Line Director will refer the matter to the Chief Clinical Officer to determine if an Investigation or other Professional Review Activity is warranted pursuant to Article XIII.

17.5. REAPPOINTMENT.

A. Appointment to the Affiliated Health Professional Staff will not exceed a two year period;

B. The Professional Staff Office will request the staff appointee to complete the Non-Physician Reappointment Application. Information requested may include:

1. Completed and signed job description;
2. A supervising physician signed assessment;
3. Attestation of Continuing Education hours obtained annually as required by the member's licensing board;
4. Health status (including drug/alcohol abuse);
5. Documented licensure, registration or certification (if applicable); and,
6. Adequate liability insurance (if applicable).

C. The Affiliated Health Professional Staff appointee will submit the Reappointment Application to the Professional Staff Office for processing. The completed form will then be submitted to the Physician Sponsor who will evaluate the appointee, complete the Review and Assessment section of the form, and submit a recommendation for reappointment/non-reappointment and authorization to provide care to the appropriate Chief of Service or Service Line Director;

D. The application is then reviewed by the Credentialing Coordinator. 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; and,

E. The Credentials Committee will 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 will not exceed 120 days.

A. On a case-by-case basis, upon recommendation of the Chief Clinical Officer, the CEO or their designees may grant temporary authorization to provide care for an important patient care need that requires immediate authorization to practice. This temporary authorization may be granted for a limited period of time, while full credentials information is verified and approved. Such authorization requires, at a minimum, verification of current licensure and current competence. 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 Chief of Service or Service Line Director delineating the applicant's relevant training and experience.

17.7. SUSPENSION AND TERMINATION OF AUTHORIZATION TO PROVIDE CARE.

A. Temporary privileges will terminate either when:

1. The Credentials Committee takes action on the appointment and authorization to provide care; or,
2. Upon recommendation by the applicable Chief of Service or Service Line Director, when the application review process has not progressed to completion.

B. With or without cause, an 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 appointee's Chief of Service or Service Line Director, 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; and,

C. Affiliated Health Professional Staff members who are employees of 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 due process procedures stated within these Bylaws.

ARTICLE XVIII: RULES AND REGULATIONS[131]

18.1. The Medical Staff may adopt necessary Rules and Regulations to implement these Bylaws, subject to approval by the Board of Trustees. These Rules and Regulations will 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[132]

19.1. The UAMS Medical Center of Arkansas Medical Staff Bylaws and Rules and Regulations, will be adopted upon a two-thirds vote of the Medical Staff. Upon adoption, the Bylaws will replace any previous Bylaws of the Medical Staff. These Bylaws will become effective when approved by the Board of Trustees.[133]

ARTICLE XX: AMENDMENTS TO BYLAWS[134]

20.1. The Medical Staff Bylaws, Rules and Regulations cannot be unilaterally amended.[135] The Medical Staff may propose changes to the Bylaws, Rules and Regulations when necessary

[131] MS.01.01.01 EP25
[132] MS.01.01.01 EP24
[133] MS.01.01.01 EP2,8,24
[134] MS.01.01.01 EP24
[135] MS.01.01.01 EP8, EP9, EP10, EP24, EP25

to reflect current and future practices of the Medical Staff organization. Proposed changes to the Bylaws or Rules and Regulations must be presented in writing to the Medical Board through the appropriate Medical Board committee. If the proposed amendments are approved by the Medical Board, they will be presented to the Medical Staff for a vote. An amendment will be passed upon a two-thirds vote of the Medical Staff. Amendments will become effective when approved by the Board of Trustees. All approved amendments will be communicated to the Medical Staff.[136]

20.2. 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.

20.3. 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 no conflict is submitted in writing to the Chief Clinical Officer within five (5) business days of receipt of notification, the provisional amendment stands. If the stated concerns cannot be resolved through the established Medical Board committees, the issue will be addressed according to the "Conflict Management Policy."[137]

ARTICLE XXI: GOVERNING LAW

21.1. These Medical Staff Bylaws will 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 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

[136] MS.01.01.03
[137] MS.01.01.01 EP11

Improvement Act of 1986, the provisions of the Health Care Quality Improvement Act of 1986 will govern.[138]

ARTICLE XXII: PRIVILEGES AND IMMUNITIES

22.1. Any committees of the Medical Board and/or of the Board of Trustees who conduct Professional Review Activities and any individuals within the Hospital authorized to conduct Professional Review Activities, are organized as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986 and the Arkansas Peer Review Fairness Act of 2013. Each Professional Review Body hereby claims all privileges and immunities afforded to it by federal and state law. Any action by a Professional Review Body pursuant to these Medical Staff Bylaws will be made based upon 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 with 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

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

[138] MS.01.01.01 EP4

THE 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:** The UAMS Medical Staff are responsible for medical care of patients. 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, perform medical screening examinations and provide emergency service care.

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 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; and,
   - **B.** Each clinical service will 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 will be available to all staff members and Hospital employees through the UAMS Intranet.

5. **HISTORY AND PHYSICAL EXAM[139]:** The Medical Staff is responsible for ensuring that the history and physical examination (H&P) report is completed prior to surgery, or within the first twenty-four (24) hours of admission to inpatient or observation services by Active or Courtesy Staff, Advanced Practice Staff, or Housestaff. The H&P must be entered into the Electronic Health Record and attached to the current admission encounter. The H&P should reflect an assessment related to the chief complaint, reason for admission, or scheduled procedure. The H&P must contain the following:
   A. Chief Complaint;
   B. Present illness with dates or approximate dates of onset;
   C. Past medical history/surgical history;
   D. Medications;
   E. Allergies;
   F. Relevant family and social history;
   G. Review of systems;
   H. Physical examination which should include at a minimum: head and neck exam, heart exam; lung exam; abdomen exam; a global assessment of neurological function; additional specialty or subspecialty examination appropriate to the admitting service;
   I. Provisional diagnosis(es) or a statement of the conclusions or impressions drawn from the H&P. In case of an emergency, the provisional diagnosis will be stated as soon after admission as possible; and,
   J. Plan for evaluation and treatment.

6. **CONTINUING EDUCATION:** Members of the Active, Courtesy and Advanced Practice Staff will obtain continuing education hours annually as required by the member's licensing board and provide attestation of such at the time of each reappointment.

7. **PROFESSIONAL CONDUCT:** Medical Staff members will 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.

8. **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 will be conducted in accordance with applicable UAMS clinical policies and procedures.

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[139] MS.01.01.01 EP16

Individuals participating in clinical trials will have the same rights and privileges as any other UAMS patient.

9. **REPORTING REQUIREMENTS:** Medical Staff members will report to their Chief of Service or Service Line Director, Department Chair, Department of Patient Safety and Relations 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 will be made as soon as reasonably practical after the member receives notice of the lawsuit/complaint.

Adopted by the Medical Staff of the University of Arkansas for Medical Sciences, Medical Center on October 12, 2020

_________________________________ ____________

Michelle Krause, MD **Date**
Chief of Staff

Approved and upheld by the Board of Trustees of the University of Arkansas on November 20, 2020

__________________________________ ______________

John Goodson **Date**
Chairman, Board of Trustees

November 2020 Hospital Bylaws, Rules and Regulations Signature Page