

APPENDIX XXXVIII



Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

SUMMARY OF ACTIONS TAKEN

December 2, 2025 – Wexner Medical Center Board Meeting

Members Present:

Gary R. Heminger
Tomislav B. Mitevski
Juan Jose Perez
George A. Skestos
Kara J. Trott

Robert H. Schottenstein
Stephen D. Steinour
Cindy Hilsheimer
Amy Chronis
John W. Zeiger (ex officio)

Walter E. Carter Jr. (ex officio)
Ravi V. Bellamkonda (ex officio)
Michael Papadakis (ex officio)
John J. Warner (ex officio)

Members Present via Zoom:

Kendall C. Buchan

Hiroyuki Fujita

Members Absent:

Leslie H. Wexner

PUBLIC SESSION

The Wexner Medical Center Board convened for its 56th meeting on Tuesday, December 2, 2025, via Zoom and in person at Longaberger Alumni House on Ohio State's Columbus campus. Board Secretary Jessica A. Eveland called the meeting to order at 1:59 p.m.

Item for Action:

1. Approval of Minutes: No changes were requested to the August 19, 2025, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

Items for Discussion:

Mr. Rick Lucas, president and executive director of the Ohio Nurses Association and, joined the Board to share concerns related to the safety of healthcare providers within the medical center in the areas surrounding it. He related alleged incidents and called for enhanced accountability of leadership, greater investments in safety infrastructure and staffing, additional protocols to protect staff and patients, and the hiring of additional healthcare staff.

2. Chief Executive Officer's Report: Dr. John Warner, chief executive officer of the Wexner Medical Center and executive vice president at Ohio State, noted that this meeting would be the Board's last prior to the opening of the new University Hospital. Staff and healthcare providers held their first of three "dress rehearsals," opportunities to run different scenarios to learn how to move and work in the new space, in October. The second will occur on December 4. The medical center is on track to meet its hiring goals for the new facility, having filled 2,030 of 2,178 planned positions.

Dr. Warner celebrated the 25th anniversary of the Dorothy M. Davis Heart and Lung Research Institute as well as the awarding of the Jay and Jeanie Schottenstein Prize in Cardiovascular Surgery to Dr. Joseph Wu of the Stanford Cardiovascular Institute. He then thanked Dr. Carol



Bradford for her contributions to the College of Medicine following an announcement on December 1 that she will be stepping down from her leadership post at the end of the year. Dr. Warner closed by recognizing the record \$29.2 million raised by Pelotonia this year.

- 3. James Cancer Hospital Report: Chief Executive Officer Kimryn Rathmell began her remarks by recounting the longstanding success of Pelotonia. Including the \$29.2 million raised this year, the organization has raised \$339 million over the past 17 years to fund lifesaving cancer research and care. She then explained the need for an expanded, more audacious vision for The James driven by a four-part framework: enabling a curiosity-driven culture, expanding our reach, providing ultimate individualized care and learning from every encounter. Work is already underway to empower providers and staff at The James to achieve these aims.

(See Attachment XXXIV for background information, page 980)

- 4. Wexner Medical Center Financial Report: Chief Financial Officer Richard Silveria provided a high-level report out of the medical center's financial results. The first quarter of FY26 was positive for the Wexner Medical Center, setting a strong foundation for the year. Driven by strong surgical volumes, infusion activity as well as a favorable service mix, the health system's total operating revenue during this period was \$1.38 billion, compared to the budget of \$1.35 billion. This puts the health system 2.3% ahead of budget and 16.3% ahead of FY25. The health system ended the quarter with \$1.25 billion in expenses compared to the budget of \$1.24 billion, or 0.4% above budget driven by the strong volumes in FY26. Overall, the health system's expense and labor management were solid and in line with volumes for the fiscal year. The medical center closed Q1 with 126 days cash on hand compared to the target of 121.5.

(See Attachment XXXV for background information, page 992)

Items for Action:

- 5. Resolution No. 2026-50, Recommend Approval to Enter Into/Increase Professional Services and Increase Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
EAST HOSPITAL- TOWER – ELEVATOR RENOVATIONS

APPROVAL TO INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS
EAST HOSPITAL – FIRE SUPPRESSION

APPROVAL TO INCREASE CONSTRUCTION CONTRACTS
WMC OUTPATIENT CARE POWELL

Synopsis: Authorization to enter into/increase professional services and construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following project; and

	Prof. Serv. Approval Requested	Total Requested	
East Hospital – Tower – Elevator Renovations	\$1.7M	\$1.7M	Auxiliary funds



WHEREAS in accordance with the attached materials, the University desires to increase professional services and construction contracts for the following project; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
East Hospital – Fire Suppression	\$0.6M	\$6.8M	\$7.4M	Auxiliary funds

WHEREAS in accordance with the attached materials, the University desires to increase construction contracts for the following project; and

	Construction Approval Requested	Total Requested	
WMC Outpatient Care Powell	\$4.7M	\$4.7M	Auxiliary funds

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the projects listed above be recommended to the University Board of Trustees for approval.

BE IT FURTHER RESOLVED, That the President and/or Senior Vice President for Business and Finance be authorized to enter into professional services and construction contracts for the projects listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

(See Attachment XXXVI for background information, page 997)

6. Resolution No. 2026-51, Approval of the East Hospital Level III Trauma Center Verification:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the triennial review of the Level III Trauma Center for East Hospital, is proposed.

WHEREAS, the mission of the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and East Hospital, is to improve people's lives through innovation in research, education, and patient care; and

WHEREAS, the Ohio State University Hospitals continue to provide emergency, specialty, and subspecialty clinical trauma services, as well as professional and public education, injury prevention, research, and performance improvement programs (collectively, the "Trauma Program"); and

WHEREAS, the Ohio State University Hospitals intend to continue to meet all requirements and criteria to maintain Level III Trauma Center verification at East Hospital and support its Trauma Program, including ensuring that the necessary personnel, facilities, and equipment are made available to support a Level III Trauma Center at East Hospital; and



THE OHIO STATE UNIVERSITY

WHEREAS, the triennial review of a Level III Trauma Center at East Hospital was approved by the Ohio State University Hospitals Medical Staff Administrative Committee on October 8, 2025; and

WHEREAS, the triennial review of a Level III Trauma Center at East Hospital was approved by the Quality and Professional Affairs Committee on October 28, 2025:

NOW THEREFORE

BE IT RESOLVED, That The Ohio State University Wexner Medical Center Board and The Ohio State University Board of Trustees hereby commit to maintain the high standards needed to provide optimal care to all trauma patients and supports the East Hospital Level III Trauma Center verification by the American College of Surgeons Committee on Trauma.

(See Attachment XXXVII for background information, page 1000)

7. Resolution No. 2026-52, Approval of Amendments to the Bylaws of the Medical Staff – Ohio State University Hospitals d/b/a OSU Wexner Medical Center:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: The amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

WHEREAS a summary of the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on September 10, 2025; and

WHEREAS on October 28, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the *Bylaws of the Medical Staff* of The Ohio State University Hospitals:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and The Ohio State University Board of Trustees hereby approve the amendments to the *Bylaws of the Medical Staff* for The Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment XXXVIII for background information, page 1003)

8. Resolution No. 2026-53, Approval of Amendments to the Bylaws of the Medical Staff – The Ohio State University Comprehensive Cancer Center, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: The amendments to the *Bylaws of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.



WHEREAS a summary of the proposed amendments to the *Bylaws of the Medical Staff* of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the *Bylaws of the Medical Staff* of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on September 19, 2025; and

WHEREAS on October 28, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the *Bylaws of the Medical Staff* of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and The Ohio State University Board of Trustees hereby approve the amendments to the *Bylaws of the Medical Staff* of the James Cancer Hospital.

(See Attachment XXXIX for background information, page 1066)

9. Resolution No. 2026-54, Approval of Amendments to the *Medical Staff Rules and Regulations* – The Ohio State University Comprehensive Cancer Center, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute;

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: The amendments to the *Medical Staff Rules and Regulations* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.

WHEREAS a summary of the proposed amendments to the *Medical Staff Rules and Regulations* of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the *Medical Staff Rules and Regulations* of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on September 19, 2025; and

WHEREAS on October 28, 2025, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the *Medical Staff Rules and Regulations* of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board and The Ohio State University Board of Trustees hereby approve the amendments to the *Medical Staff Rules and Regulations* for The James.

(See Attachment XL for background information, page 1126)



Action: Upon the motion of Mr. Perez, seconded by Dr. Warner, the Wexner Medical Center Board recommended these items for approval by roll-call vote with the following members present and voting: Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Ms. Trott, Dr. Buchan, Mr. Schottenstein, Mr. Steinour, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Dr. Bellamkonda, Mr. Papadakis and Dr. Warner.

EXECUTIVE SESSION

It was moved by Dr. Warner and seconded by Mr. Zeiger that the Wexner Medical Center Board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential.

A roll-call vote was taken, and the Board voted to go into executive session with the following members present and voting: Mr. Heminger, Mr. Mitevski, Mr. Perez, Mr. Skestos, Ms. Trott, Dr. Buchan, Mr. Schottenstein, Mr. Steinour, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Mr. Zeiger, President Carter, Dr. Bellamkonda, Mr. Papadakis and Dr. Warner.

The Wexner Medical Center Board entered executive session at 2:40 p.m. and adjourned at 5:35 p.m.



OSUCCC – James Wexner Medical Center Board Presentation

December 2, 2025
W. Kimryn Rathmell, MD, PhD
Chief Executive Officer

ATTACHMENT XXXIV

Meetings

The James



THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

Vision

**To create a
cancer-free world.
One person,
one discovery at a time.**



Vision

**To create a
cancer-free world.
Every person,
Every discovery,
Every time.**



How will we do this?

Enable a Curiosity-Driven Culture

Foster an environment where curiosity inspires innovation and continuous learning across teams.

Expand Our Reach

Increase access and impact by reaching more communities across the state and country.

Provide Ultimate Individualized Care

Deliver tailored healthcare solutions using advanced technology to meet individual patient needs.

Learn From Every Encounter

Improve outcomes by gathering insights and knowledge from every person we encounter.



Impact 2035 Alignment

Impact 2035 Strategic Priorities	Enable Curiosity-Driven Culture	Expand Our Reach	Provide Ultimate Individualized Care	Learn from Every Encounter
Exceptional Care	✓	✓	✓	✓
Purposeful Growth	✓	✓	✓	✓
Best-in-Class Operating Model	✓	✓	✓	✓
High Impact Discovery	✓	✓	✓	✓
A Healthier Ohio	✓	✓	✓	✓
Accelerated Health Care Transformation	✓	✓	✓	✓
Reimagined Learning and Development	✓	✓	✓	✓
Workplace of Choice	✓	✓	✓	✓

People are the center of our vision.



Our Patients,
Families,
Caregivers, and
Communities



Our Team



Our Organization

Person-Centered Approach

- Commitment to prevention
- Truly 'personalized' care
- Comprehensive phenotyping for all tumor types
- Person-centered efficiencies and supportive care services
- Intentional and integrated use of telehealth
- Distributed clinical trials – centralized to the James





Empowering Our Team

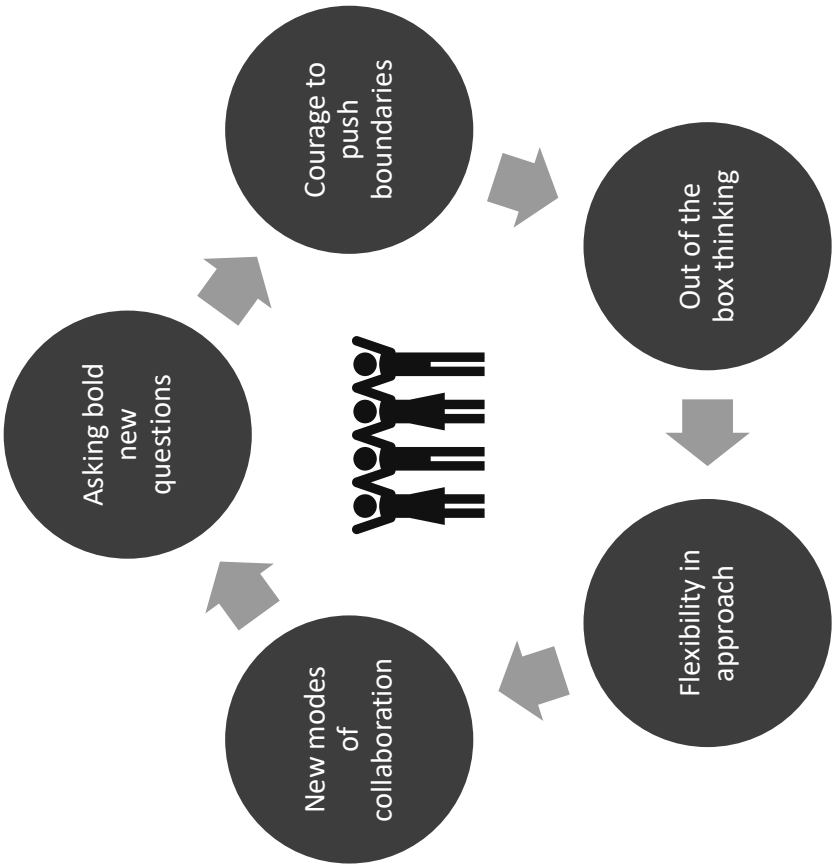
- Every person and role matters, and we are all owners of our vision
- Innovative training programs
- Impactful mentorship and coaching
- Transformative recruitment
- Optimizing design innovation – and connection
- Culture of ownership, recognition, gratitude, pride

Organizational Resources and Infrastructure

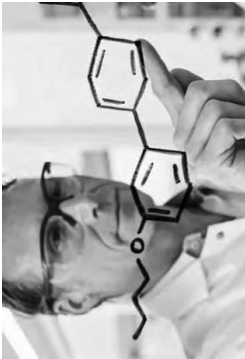
- Collaborative research space
- Best-in-class clinical space
- Flexible office solutions
- Sustainable financial resources



Creating the ecosystem needed to enable our virtuous cycle

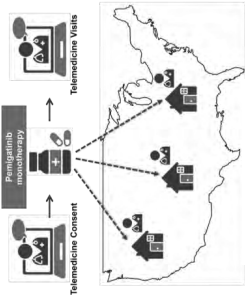


First, Best, Only



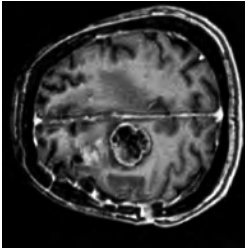
FIRST Phase 1 testing of JBZ-001 – fully discovered and developed at OSU

Targets dihydroorotate dehydrogenase (DHODH), novel pathway critical for many cancers



BEST Launch of first ever nationwide study of 100% telehealth clinical trial

Reaching patients where they are advancing discovery to improve outcomes



ONLY availability of GARP CAR-T cell engineered for treatment of recurrent glioma

Tackling the hardest of the hard with innovative treatments



Thank You

Connect with us on social media:



The James



cancer.osu.edu



**Wexner Medical Center Board
Financial Report
Public Session
December 2, 2025**

The Ohio State University Health System

Consolidated Statement of Operations
For the YTD ended September 30, 2025
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	1,383,282	1,351,794	31,488	2.3%	1,189,815	16.3%
Operating Expenses						
Salaries and Benefits	524,900	530,837	5,937	1.1%	483,784	-8.5%
Resident/Purchased Physician Services	74,931	74,482	(449)	-0.6%	64,071	-16.9%
Supplies/Pharmaceuticals/Other	572,757	562,595	(10,162)	-1.8%	480,848	-19.1%
Depreciation	68,091	68,091	-	0.0%	65,733	-3.6%
Interest	12,120	12,120	-	0.0%	12,778	5.1%
Total Expense	1,252,799	1,248,125	(4,674)	-0.4%	1,107,214	-13.1%
Gain (Loss) from Operations (pre MCI)	130,483	103,669	26,814	25.9%	82,601	58.0%
Medical Center Investments	(79,845)	(77,763)	(2,082)	-2.7%	(59,390)	-34.4%
Income from Investments	15,546	13,319	2,227	16.7%	17,629	-11.8%
Other Gains (Losses)	14,644	14,503	141	1.0%	9,437	55.2%
Excess of Revenue over Expense	\$ 80,828	\$ 53,728	\$ 27,100	50.4%	\$ 50,277	60.8%
Margin Percentage	5.8%	4.0%	1.8%	47.0%	4.2%	1.6%
EBIDA	\$ 161,039	\$ 133,939	\$ 27,100	20.2%	\$ 128,788	25.0%
EBIDA Margin Percentage	11.6%	9.9%	1.7%	17.5%	10.8%	0.8%

The Ohio State University Wexner Medical Center

Combined Statement of Operations

For the YTD ended: September 30, 2025

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	1,815,705	1,791,381	24,324	1.4%	1,596,839	13.7%
Operating Expenses						
Salaries and Benefits	944,171	950,920	6,749	0.7%	860,393	-9.7%
Resident/Purchased Physician Services	74,931	74,482	(449)	-0.6%	64,071	-16.9%
Supplies/Pharmaceuticals/Other	680,148	688,137	(12,011)	-1.8%	582,200	-16.8%
Depreciation	69,211	69,211	1	0.0%	66,947	-3.4%
Interest	12,169	12,178	9	0.1%	12,831	5.2%
Total Expense	1,780,630	1,774,929	(5,701)	-0.3%	1,586,443	-12.2%
Gain (Loss) from Operations	35,076	16,453	18,623	113.2%	10,396	237.4%
Income from Investments	18,893	17,892	1,002	5.6%	22,047	-14.3%
Other Gains (Losses)	13,167	15,611	(2,444)	-15.7%	8,978	46.7%
Excess of Revenue over Expense	\$ 67,136	\$ 49,956	\$ 17,180	34.4%	\$ 41,422	62.1%
Margin Percentage	3.7%	2.8%	0.9%	32.6%	2.6%	1.1%
EBIDA	\$ 148,516	\$ 131,345	\$ 17,170	13.1%	\$ 121,200	22.5%
EBIDA Margin Percentage	8.2%	7.3%	0.9%	11.6%	7.6%	0.6%

* Combined Medical Center includes Health System, OSUP, and College of Medicine.

** This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

The Ohio State University Wexner Medical Center

Combined Balance Sheet
As of: September 30, 2025
(in thousands)

	Sep 2025	June 2025	Change
<u>Assets</u>			
Cash	\$ 1,481,039	\$ 1,592,347	\$ (111,308)
Net Patient Receivables	874,837	839,574	35,262
Other Current Assets	266,863	244,749	22,115
Assets Limited as to Use	845,422	842,180	3,242
Property, Plant & Equipment - Net	4,135,296	4,049,573	85,723
Other Assets	645,979	630,290	15,689
Total Assets	\$ 8,249,436	\$ 8,198,713	\$ 50,723
<u>Liabilities & Net Position</u>			
Current Liabilities	\$ 711,142	\$ 709,652	\$ 1,490
Other Liabilities	421,789	420,478	1,311
Total Debt	1,326,135	1,348,084	(21,949)
Net Position	5,790,369	5,720,498	69,871
Liabilities and Net Position	\$ 8,249,436	\$ 8,198,713	\$ 50,723
Days Cash on Hand	124.2	133.8	(9.6)
Net Days in Accounts Receivable	55.1	52.7	(2.3)
Debt to Capital	18.6%	19.1%	0.4%

* Combined Medical Center includes Health System, OSUP, and College of Medicine.
** This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.



Thank You

Project Data Sheet for Board of Trustees Approval

East Hospital - Tower - Elevator Renovations

OSU-265016 (REQ ID# WMC240003)

Project Location: East Hospital - Tower (0397)

• Approval Requested and Amount	
Professional services	\$1.7M
Total requested	\$1.7M

• Project Budget	
Professional services	\$1.7M
Construction w/contingency	\$12.3M
Total project budget	\$14.0M

• Project Funding	
Auxiliary funds	

• Project Schedule	
BoT professional services approval	12/25
Design	02/26 – 08/26
BoT construction approval	09/26
Construction	10/26 – 12/28
Facility opening	12/28

• Project Delivery Method	
Construction Manager at Risk	

- **Planning Framework**
 - o This project is included in the FY26 Capital Investment Plan and will cash flow over the next two years.
- **Project Scope**
 - o This project is a four-phase elevator modernization project at OSU East Tower which will replace all four public elevators sequentially, always maintaining three elevators in service to minimize disruption.
 - o Scope includes full replacement of elevator equipment and interior finishes to improve reliability, safety, and user experience.
- **Approval Requested**
 - o Approval is requested to enter into professional services contracts.



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- **project team**
 - University project manager: Jackson, Clay
 - AE/design architect: TBD
 - CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

East Hospital - Fire Suppression

OSU-220196 (REQ ID# WMC220000001; WMC2400001)

Project Location: East Hospital - Main (0398), East Hospital - Tower (0397)

Approval Requested and Amount

Professional services	\$0.6M
Construction w/contingency	\$6.8M
Total requested	\$7.4M

Project Budget

Professional services	\$1.4M
Construction w/contingency	\$12.2M
Total project budget	\$13.6M

Project Funding

Auxiliary funds

Project Schedule

BoT professional services approval	05/22
Design	10/22 – 06/27
BoT construction approval	11/23
Construction (phased)	05/25 – 06/28
BoT construction approval	12/25
Facility opening	06/28

Project Delivery Method

Construction Manager at Risk

Planning Framework

- This project was included in the FY23 Capital Investment Plan with cash flow programmed over several fiscal years.

Project Scope

- This project will extend the fire suppression system to all non-sprinklered areas of OSU East Hospital bringing the building into compliance.
- Scope includes the installation of a new fire pump serving the full facility. Work will be phased within occupied hospital areas.
- This project faced multiple delays and limited contractor interest. Scope and budget have been clarified, resulting in a successful bid with the CMR.

Approval Requested

- Approval is requested to increase professional services and construction contracts.



project team

University project manager: Flaherty, Brendan
AE/design architect: Karpinski Engineering
CM at Risk or Design Builder: Messer Construction

Project Data Sheet for Board of Trustees Approval

WMC Outpatient Care Powell

OSU-220880 (REQ ID# WMC229002; WMC240009)

Project Location: Outpatient Care Powell (1046)

- **Approval Requested and Amount**

Construction w/contingency	\$4.7M
Total requested	\$4.7M
- **Project Budget**

Professional services	\$23.0M
Construction w/contingency	\$164.7M
Total project budget	\$187.7M
- **Project Funding**

Auxiliary funds
- **Project Schedule**

BoT professional services approval	05/22
Design	06/22 – 09/23
BoT construction approval	02/24
Construction	04/24 – 06/26
Facility opening	08/26



- **Project Delivery Method**

Construction Manager at Risk
- **Planning Framework**
 - o This project was included in the FY23 Capital Investment Plan with cash flow programmed over several fiscal years.
 - o Consistent with the strategic plans of the university and Wexner Medical Center to provide medical services within community-based ambulatory facilities.
- **Project Scope**
 - o Design and construction of a five-story medical office building and a two-story ambulatory health center which includes imaging, outpatient rehab/PT, endoscopy, and support services.
 - o The James added cancer infusion services to the 4th and 5th floors of the facility and work is underway using contingency funds.
 - o The proposed funding increase supports an MRI upgrade from 1.5T to 3.0T, and medical and lab equipment for infusion.
- **Approval Requested**
 - o Approval is requested to increase construction contracts.

-
- **project team**

University project manager: Rice, George
AE/design architect: DLR Group
CM at Risk or Design Builder: CK Construction

OSUWMC Adult Level III Trauma Center



Standard 1.1 Administrative Commitment

“In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle”

1.1 Administrative Commitment—TYPE I

Applicable Levels	Resources
LL, LIL, LIII, PTCL, PTCH	None
Definition and Requirements	References
In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.	None
Additional Information	
Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth. This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.	
Measures of Compliance	
Documentation that demonstrates compliance, including: • Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification • Commitment to adherence to the standards required for the level of verification • Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards	

WMC Board Approval Request

Documented Compliance:

- “Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification”
- “Commitment to adherence to the standards required for the level of verification”
- “Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards”

1.1 Administrative Commitment—TYPE I

Applicable Levels	Resources
LI, LII, LIII, PTCL, PTCII	None
Definition and Requirements	References
In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.	None
Additional Information	
Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth. This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.	
Measures of Compliance	
Documentation that demonstrates compliance, including: • Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification • Commitment to adherence to the standards required for the level of verification • Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards	

ATTACHMENT XXXVIII

Joint Bylaws Committee Meeting University Hospitals and The James

August 21, 2025

Summary of Proposed Amendments

University Hospitals Bylaws

- Proposed changes to 3335-43-04 (Membership) and 3335-43-07 (Categories of the medical staff) describing the required period of active clinical practice from “two” years to “three” to bring in-line with current recredentialing cycles.
- Proposed addition of granting telemedicine privileges by proxy as permitted by Centers for Medicare and Medicaid Services Conditions of Participation and by Joint Commission standards – added at 3335-43-07(K)(11).

University Hospitals Rules and Regulations

- No proposed amendments



Chapter 3335-43 - Bylaws of the Medical Staff of The Ohio State University Hospitals

Updated July 25, 2025

3335-43-01 Medical staff name.

The board of trustees of the Ohio state university, by official action on September 13, 1963, established "the Ohio state university hospitals." In accordance with Chapters 3335-93-01 to 3335-93-03 and 3335-101-04 of the Administrative Code, the Ohio state university Wexner medical center board (herein called Wexner medical center board) has delegated to the medical staff of the Ohio state university hospitals the responsibility to prepare and recommend adoption of these bylaws. "The medical staff of the Ohio state university hospitals" shall be the name of the hospitals' medical staff organization.

(Board approval date: 5/14/2010, 11/7/2014)

3335-43-02 Purpose.

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state university Wexner medical center board for the quality of care provided to the patients of the Ohio state university hospitals, shall be:

- (A) To strive to maintain quality standards of patient care for all patients admitted to the Ohio state university hospitals, consistent with an active teaching environment, realizing that the care and treatment of the individual patient is the medical responsibility of the member of the attending, community affiliate A and community affiliate D medical staff to whose care the patient is admitted or transferred.
- (B) To support educational and research programs; elevate and advance the educational standards of our professions, including, but not limited to, pre- and post-M.D. students, nurse students, graduate nurse students, students of the allied medical professions, and students of other health professional colleges; and provide research programs to enhance and advance the educational and patient-care programs.
- (C) To provide a means whereby medical problems may be reviewed; policies and procedures discussed; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, organization, and discipline within the medical staff and harmonious cooperation and understanding among the units comprising the Ohio state university hospitals.
- (D) To provide service, education and research programs to benefit the mental, physical, and environmental health of the citizens of the state of Ohio; dedicate itself to be responsive to the needs of its patients and to communicate effectively concerning matters of patient care; and encourage dissemination of medical knowledge to health professionals and the public, and conduct research for the prevention and treatment of disease.
- (E) To govern medical staff and credentialed practitioners these bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014, 4/6/2018, 8/15/2023)

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3335-43-03 Patients.

- (A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, community affiliate A and community affiliate D medical staff to whose care the patient is admitted or transferred within the Ohio state university hospitals and to licensed health care professionals being granted clinical privileges under these bylaws.
- (B) There shall be only one category or classification of patients in the Ohio state university hospitals, and those patients are the private patients of the medical staff under whose care they are admitted. Patients admitted to the Ohio state university hospitals who, at the time of admission, have not requested or selected a member of the medical staff to attend them shall be assigned by the chief of the appropriate clinical division or department or their designees, to a member of the medical staff for their care and treatment.
- (C) All patients admitted to the Ohio state university hospitals should cooperate and be an integral part of the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the Ohio state university hospitals or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patient's representative, of their right to refuse participation. Students, including pre- and post-M.D., but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned upon admission to the Ohio state university hospitals or transfer within the Ohio state university hospitals' services. The Ohio state university hospitals respect the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's right to refuse care treatment and services, in accordance with law and regulation.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014, 8/15/2023)

3335-43-04 Membership.

- (A) Qualifications.
 - (1) Membership on the medical staff of the Ohio state university hospitals is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, the Wexner medical center board and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same procedures as all other applicants for the medical staff.
 - (2) All members of the medical staff of the Ohio state university hospitals shall, except as specifically provided in these bylaws, be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry. All members, except for physician scholar medical staff, shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of their

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profession, dedication to educational and research-goals, and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at university hospitals will be given the high quality of medical care provided at university hospitals, shall be qualified for membership on the medical staff of the Ohio state university hospitals.

All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The chief medical officer of the medical center, medical directors, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant. All members of the medical staff and licensed health care professionals will comply with medical staff and the Ohio state university policies regarding employee and medical staff health and safety; uncompensated care; and will comply with appropriate administrative directives and policies to avoid disrupting those operations of the Ohio state university hospitals which adversely impact overall patient care or which adversely impact the ability of the Ohio state university hospitals employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety. Annual education and training approved by the medical staff administrative committee or as required by the Wexner medical center to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosure. Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

- (3) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental health care programs.
 - (a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental programs.
 - (b) Exclusion of any medical staff member or credentialed provider from participation in any federal or state government program or suspension from participation, in whole or part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the Ohio state university hospitals and the immediate lapse of clinical privileges at the Ohio state university hospitals as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

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- (c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.
- (4) An applicant for membership shall at the time of appointment or reappointment, be and remain board certified in his or her primary area of practice at the Ohio state university hospitals. This Board certification must be approved by at least one of the American board of medical specialties, or other applicable certifying boards, including certifying boards if applicable for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be and remain certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals.
- (5) All applicants must demonstrate recent clinical activity in their primary area of practice during the last ~~two~~three years to satisfy minimum threshold criteria for privileges within their clinical departments.
- (6) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(3) to (A)(5) of this rule may be requested and considered as follows:
 - (a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden of demonstrating that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.
 - (b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.
 - (c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the quality and professional affairs committee of the Ohio state university Wexner medical center and the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
 - (d) The Ohio state university Wexner medical center board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted. Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.

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- (e) Waiver requests for the threshold eligibility requirement listed in paragraph (A)(3) of this rule may only be considered for applicants who have voluntarily opted out of governmental health care programs. Applicants who have been excluded or suspended shall be ineligible to request a waiver.
 - (f) Waivers to requirements prescribed by regulatory accrediting or other external agencies will not be granted.
 - (7) Any medical staff member whose membership has been terminated pursuant to paragraph (A)(3) or (A)(4) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code. Any licensed health care professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph (G)(3) of rule 3335-43-07 of the Administrative Code.
 - (8) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.
- (B) Application for membership.

Initial application for medical staff membership for all categories of the medical staff shall be made by the applicant to the chief of the clinical department on forms prescribed by the medical staff administrative committee stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the applicant meets the qualifications outlined in paragraph (A) of this rule. The application shall include written statements of the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government-issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant shall agree that membership on the medical staff requires participation in the peer review process of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in this review process as long as the peer review was taken in the reasonable belief that it was in furtherment of quality health care based upon a reasonable review and appropriate procedural due process. In order to optimize the clinical organization resource utilization and planning of the Ohio state university hospitals, the chief of the clinical department may require that the community affiliate D medical staff member identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant, which shall be made a part of the application for appointment. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

- (C) Terms of appointment. Initial appointment to the medical staff shall be for a period not to exceed thirty-six months. During the first six months of the initial appointment, except for medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by of the chief of the clinical department with oversight by the credentials committee and the medical staff administrative committee. Following the six-month FPPE period, the chief of the clinical department may: 1. recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee; 2. extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a total of twelve months for purposes of further monitoring and evaluation; or 3. terminate the initial appointee's medical staff

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membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

- (D) Ethics and ethical relationship. The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American psychological association, American osteopathic association and the American podiatric medical association shall govern the professional ethical conduct of the respective members of the medical staff.
- (E) Procedure for appointment.
 - (1) The written and signed application for membership on the medical staff shall be presented to the applicable chief of the clinical department. The applicant shall include in the application a signed statement indicating the following:
 - (a) If the applicant should be accepted to membership on the medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board and the board of trustees of the Ohio state university.
 - (b) The applicant consents to be interviewed in regard to the application.
 - (c) The applicant authorizes the Ohio state university hospitals to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.
 - (d) The applicant consents to the Ohio state university hospitals' inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges for which the applicant is seeking as well as the applicant's professional ethical qualifications for medical staff membership.
 - (e) The applicant releases from any liability:
 - (i) All representatives of university hospitals for acts performed in connection with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith; and
 - (ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the Ohio state university hospitals staff, Ohio state university Wexner medical center board members and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith.
 - (f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
 - (g) The applicant further agrees to disclose to the chief medical officer of the Ohio state university hospitals the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

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- (h) The applicant agrees that acceptance of membership on the medical staff of the Ohio state university hospitals authorizes the Ohio state university hospitals to conduct any appropriate health assessment including but not limited to drug or alcohol screens on a practitioner at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical department or the chief medical officer of the Ohio state university hospitals or their authorized designees.
- (2) The purpose of the health assessment shall be to ensure that the member of the medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the member is permitted to exercise by reason of medical staff membership. If, at the time of the initial request for a health assessment, and at any time a medical staff member refuses to participate as needed in a health assessment, including but not limited to a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or Wexner medical center board, the applicant will provide documentation the applicant's physical and mental status with sufficient adequacy to demonstrate that any patient treated by the applicant will receive care of a generally professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as a member of the medical staff.
- (3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the application is signed by the applicant and the information is verified. A completed application must contain:
 - (a) Peer recommendation from at least three individuals with "first hand" knowledge about the applicant's clinical and professional skills.
 - (b) Evidence of required immunizations.
 - (c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges.
 - (d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.
 - (e) Verification by primary source documentation of:
 - (i) Current and previous state licensure;
 - (ii) Faculty appointment (not required for community affiliate B, community affiliate C, community affiliate D or contracted category);
 - (iii) DEA registration when required for exercise of clinical privileges;
 - (iv) Graduation from an accredited medical or professional school;
 - (v) Successful completion or record of post graduate medical or professional education; and
 - (vi) Board certification active candidacy for board certification (may not be required for community affiliate B, community affiliate C and community

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affiliate D categories). or applicant qualifies for a waiver pursuant to paragraph (A)(6) of rule 3335-43-04 of the Administrative Code.

- (f) Information from the national practitioner data bank.
 - (g) Verification that the applicant has not been excluded from any federally funded health care program.
 - (h) Complete disclosure by applicant of all past and current claims, suits, and settlements, if any.
 - (i) Completion of a criminal background investigation that meets the requirements of the Wexner medical center.
 - (j) Completion of drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner medical center approved testing protocols.
 - (k) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
 - (l) Demonstration of recent active clinical practice during the last ~~two~~three years required for exercise of clinical privileges.
 - (m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.
- (4) The chief of the applicable clinical department shall be responsible for investigating and verifying the character, qualifications, and professional standing of the applicant by making inquiry of the primary source of such information and shall within thirty days of receipt of the complete application, submit a report of those findings along with a recommendation on membership and clinical privileges to the chief medical officer of the Ohio state university hospitals.
- (5) The chief medical officer shall receive all initial signed and verified applications from the chief of the clinical department and shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information.

The chief medical officer shall forward all complete applications to the credentials committee. The applicant shall have the burden of producing information for an adequate evaluation of applicant's qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn which action is not subject to hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.

If the chief of the applicable clinical department does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the chief medical officer for presentation to the credentials committee on the same basis as other applicants.

- (6) Completed applications shall be acted upon as follows:

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- (a) By the credentials committee within thirty days after receipt of a completed application from the chief medical officer.
- (b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report and recommendation of the credentials committee.
- (c) By the quality and professional affairs committee through the expedited credentialing process or Wexner medical center board within sixty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.

All applications shall be acted upon by the Ohio state university Wexner medical center board within one hundred twenty days of receipt of a completed application. These time periods are deemed guidelines only and do not create any right to have an application processed within these precise periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights specified in rule 3335-43-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.

- (7) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the chief of the clinical department's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications and ethical standing of the applicant and shall determine, through information contained in personal references and from other sources available to the credentials committee, including an appraisal from the chief of the clinical department in which clinical privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of medical staff membership and clinical privileges requested.

The credentials committee shall, within thirty days from receipt of a complete application, make a recommendation to the chief medical officer that the application be accepted, rejected, or modified. The chief medical officer shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the chief medical officer may recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session. The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the chief medical officer, along with the recommendation of the chief medical officer to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.

- (8) At any time the medical staff administrative committee first recommends non-appointment of an initial applicant for medical staff membership or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the chief medical officer to notify the applicant by certified return receipt mail that the applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-43-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-43-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-43-06 of the Administrative Code. If an applicant fails to properly request a hearing, the

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medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.

The final recommendation of the medical staff administrative committee shall be directly communicated to the Wexner medical center board by the chief medical officer, who shall make a separate recommendation to the Wexner medical center board.

When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division. The chairperson of the board shall also notify the dean of the college of medicine and the chief executive officer of the Ohio state university hospitals of the decision of the board.

(F) Procedure for reappointment.

- (1) At least ninety days prior to the end of the medical staff member's appointment period, the chief of the clinical department shall provide each medical staff member with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee. The reappointment application shall include all information necessary to update and evaluate the qualifications of the medical staff member. The chief of the clinical department shall review the information available on each medical staff member, and the chief of the clinical department shall make recommendations regarding reappointment to the medical staff and for granting clinical privileges for the ensuing appointment period. The chief of the clinical department's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the chief medical officer at least forty-five days prior to the end of the medical staff member's appointment period.

The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Reappointment to the medical staff shall be done on a regular basis for a period not to exceed thirty-six months. Only completed applications for reappointment shall be considered by the credentials committee. An application for reappointment is complete when all the information requested on the reappointment application form is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application form must contain:

- (a) Evidence of required immunizations if applicable since last appointment.
- (b) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges.
- (c) Verification of primary source documentation of:
 - (i) State licensure;
 - (ii) DEA registration when required for clinical privileges;
 - (iii) Successful completion or record of additional post graduate medical or professional education; and
 - (iv) Board certification, re-certification, or continued active candidacy for certification (may not be required for community affiliate category) or applicant qualifies for a waiver pursuant to paragraph (A) (4) of rule 3335-43-06 of the Administrative Code.

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- (d) Information from the national practitioner data bank.
 - (e) Verification that the applicant has not been excluded from any federally funded health care program.
 - (f) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines.
 - (g) Specific requests for any changes in medical staff category.
 - (h) A summary of the member's clinical activity during the previous appointment period.
 - (i) Patterns of care as demonstrated through quality assurance records.
 - (j) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
 - (k) Complete disclosure by medical staff members of claims, suits, and settlements, if any.
 - (l) Continuing medical education and applicable continuing professional education activities. Documentation of category one CME that at least in part relates to the individual medical staff member's specialty or sub-specialty area and are consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.
 - (m) Attestation of current OARRS account for all applicants who have a DEA registration.
- (2) The member for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The chief of the clinical department shall review and evaluate the reappointment application and the supporting documentation. The chief of the clinical department shall evaluate all matters relevant to recommendation, including the member's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the Ohio state university hospitals' personnel and the use of the Ohio state university hospitals' facilities for patients; relations with other physicians, other health professionals or other staff, and maintenance of a professional attitude toward patients; and the responsibility to the Ohio state university hospitals and the public.
- (3) The chief medical officer shall forward the reappointment forms and the recommendations of the chief of the clinical department to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that the same level of quality of care is delivered by all medical staff members with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

The credentials committee shall forward its recommendations to the chief medical officer at least thirty days prior to the end of the period of appointment. The chief medical officer shall transmit the completed reappointment application and the recommendation of the credentials

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committee to the medical staff administrative committee.

Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic expiration of membership and all clinical privileges at the end of the medical staff member's current appointment period, which action shall not be subject to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically expired shall be processed as a new appointment.

Failure of the chief of the clinical department to act timely on an application for reappointment shall be the same as provided in paragraph (E)(5) of this rule.

- (4) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for medical staff membership. The medical staff administrative committee shall accept, reject, or modify the request for reappointment in the same manner and with the same authority as an original application for medical staff membership. The recommendation of the medical staff administrative committee regarding reappointment of a member shall be communicated by the chief medical officer, along with the recommendation of the chief medical officer, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.
 - (5) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension or revocation of clinical privileges, the medical staff administrative committee shall instruct the chief medical officer to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to paragraphs (A) and (B) of rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (D) of rule 3335-43-05 of the Administrative Code apply. The notice by the chief medical officer shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.
 - (6) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-43-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter.
 - (7) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.
- (G) Resumption of clinical activities following leave of absence.
- (1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the chief medical officer. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the chief medical officer provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the chief medical officer and the member or credentialed provider shall be

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placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the chief medical officer that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

- (2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.
- (3) All members of the medical staff or credentialed providers who take a leave of absence for medical or non-medical reasons must be in good standing upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedures for appointment and reappointment, including deadlines for submission of application as set forth in this rule, will apply irrespective of the nature of the leave. Absence extending beyond his or her current term or failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1999, 10/1/1999, 10/5/2001, 6/7/2002, 9/6/2002, 3/5/2003, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 5/14/2010, 4/8/2011, 8/31/2012, 2/1/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 8/15/2023)

3335-43-05 Peer review and corrective action.

(A) Informal peer review.

- (1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the Ohio state university hospitals.
- (2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.
- (3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

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- (4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.
 - (5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the chief medical officer. The chief of the clinical department and the chief medical officer shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:
 - (a) The matter warrants no further action;
 - (b) Informal resolution under this paragraph is appropriate. The chief of the clinical department and the chief medical officer shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or
 - (c) Formal peer review under paragraph (B) of this rule is warranted.
 - (6) In cases where the chief of the clinical department and chief medical officer cannot agree on the need for formal peer review, the matter shall be submitted for formal peer review and determined as set forth in paragraph (B) of this rule.
- (B) Formal peer review.
- (1) Formal peer review may be initiated when a member of the medical staff of the Ohio state university hospitals:
 - (a) Fails to adhere to standards of patient care and professional conduct appropriate for a physician practicing in an academic medical center as determined by the medical staff;
 - (b) Is disruptive to the operation of the Ohio state university hospitals;
 - (c) Violates the bylaws, rules and regulations of the medical staff, the Ohio state university Wexner medical center board, or the board of trustees of the Ohio state university;
 - (d) Violates state or federal law; or
 - (e) Is responsible for acts or omissions detrimental to patient safety or to the quality or efficiency of patient care within the Ohio state university hospitals; or
 - (f) Is responsible for acts or omissions damaging to the reputation of the medical staff of the Ohio state university hospitals.

Formal peer review may be initiated by a chief of a clinical department, the chief medical officer, any member of the medical staff, the chief executive officer of the Ohio state university hospitals, the dean of the college of medicine, any member of the board of the Ohio state

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university hospitals, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the chief medical officer, and shall specifically state the conduct or activities which constitute grounds for the requested action.

- (2) The chief medical officer shall promptly deliver a written copy of the request for formal peer review to the affected member of the medical staff, in a confidential manner. The chief medical officer shall then conduct a preliminary review to verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the chief medical officer decides that no further action is warranted, the chief medical officer shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action will be taken.
- (3) Whenever the chief medical officer determines that formal peer review is warranted, he or she shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings.
- (4) The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the chief medical officer under these rules for implementing corrective action and appellate procedure if:
 - (a) The chief medical officer is the medical staff member charged;
 - (b) The chief medical officer has a financial interest or a relationship with any person that may have an improper effect on the exercise of his or her judgment in the matter, or may be perceived to have such an effect.
- (5) The formal peer review committee shall investigate every request and shall deliver written findings and recommendations for action to the chief of the clinical department. The formal peer review committee may recommend a reduction, suspension or revocation of the medical staff member's clinical privileges or other action as it deems appropriate. In making its recommendation the formal peer review committee may consider, relevant literature and clinical practice guidelines, the opinions and views expressed throughout the review process, information or explanations provided by the member under review, and other relevant information. Prior to making its report, the committee shall afford the medical staff member against whom the action has been requested an opportunity for an interview. At such interview, the medical staff member shall be informed of the specific actions or omissions alleged to constitute grounds for formal peer review and shall be given copies of any statements, reports, opinions or other information compiled at prior stages of the proceedings. The medical staff member may furnish written or oral information to the formal peer review committee at this time and shall be given an opportunity to discuss, explain, or refute the allegations and to respond to any statements, reports or opinions previously compiled in the proceedings. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action are expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.
- (6) Upon receipt of the written report and recommendation from the formal peer review committee, the chief of the clinical department shall make his or her own written recommendation for corrective action and forward that recommendation along with the findings and recommendations of the formal peer review committee to the chief medical officer.
- (7) The chief medical officer shall decide whether to accept, reject or modify the recommendation of the chief of the clinical department. If the chief medical officer decides the grounds are not

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substantiated, the chief medical officer will notify the formal peer review committee, the chief of the clinical department, the person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

If the chief medical officer finds the grounds for the requested corrective action are substantiated, the chief medical officer shall promptly notify the affected medical staff member of that decision and the corrective action that will be taken. This notice shall advise the affected medical staff member of his or her right to request a hearing before the medical staff administrative committee pursuant to rule 3335-43-06 of the Administrative Code and shall also include a statement that failure to request a hearing in the timeframe prescribed in this rule shall constitute a waiver of rights to a hearing and to an appeal on the matter and the affected medical staff member shall also be given a copy of the rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the chief medical officer shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

- (8) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, he or she shall be deemed to have waived the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.
- (9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.

(C) Composition of formal peer review committee.

- (1) When the determination that formal peer review is warranted is made, the chief of the clinical department shall select three members of the medical staff to serve on a formal peer review committee.
- (2) Whenever the questions raised concern the clinical competence of the member under review, the chief of the clinical department shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.
- (3) An external peer review consultant may serve as a member of the peer review committee whenever:
 - (a) A determination is made by the chief of the clinical department and the chief medical officer that the clinical expertise needed to conduct the review is not available on the medical staff;
 - (b) The objectivity of the review may be compromised; or
 - (c) Whenever the chief medical officer determines that an external review is otherwise advisable.

If an external reviewer is recommended, the chief of the clinical department shall make a written recommendation to the chief medical officer for selection of an external reviewer. The chief medical officer shall make the final selection of an external reviewer.

(D) Summary suspension.

- (1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or

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any portion of his or her clinical privileges suspended or appointment terminated by the chief medical officer or the chief of the member's clinical department whenever such action must be taken immediately, when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the medical staff member shall be subsequently notified in writing of the suspension by the chief medical officer. Such notice shall be issued by certified return mail to the affected medical staff member's last known address as determined by university records.

- (2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to a hearing and appeal of the suspension pursuant to rule 3335-43-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter. If a timely, written request for a hearing is made, the procedures of rule 3335-43-06 of the Administrative Code shall apply.
 - (3) Immediately upon the imposition of a summary suspension, the chief medical officer or the appropriate chief of a clinical department shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the Ohio state university hospitals at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect, the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.
- (E) Automatic suspension and termination.
- (1) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief medical officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff. The chief medical officer shall notify the chief executive officer of the Ohio state university hospitals of the action taken.
 - (2) Action by the Ohio state boards of licensure revoking or suspending a medical staff member's license or placing the member upon probation shall automatically impose the same restrictions to that member's Ohio state university hospitals' privileges.
 - (3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-43-04 and automatically relinquish his or her appointment and privileges.
 - (4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted to rule 3335-43-04(A)(3).
 - (5) If a medical staff member pleads guilty to or is found guilty of a felony which involves: violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's

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appointment and privileges shall be immediately and automatically terminated.

- (6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.
- (7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.
- (8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-43-06 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.
- (9) Resignation, termination, or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals.

(F) Reporting responsibility.

When a decision on corrective action is taken which constitutes a "formal disciplinary action" as may be defined in Ohio state law, or as may be required to be reported pursuant to federal law, including the health care quality improvement act, the chief medical officer shall ensure that a report of said action is made in order to maintain compliance with applicable state or federal law or regulations. The chief medical officer shall ensure that such reports are amended as may be required to reflect subsequent actions taken under the hearing and appeal rights afforded in these bylaws.

When applicable, any recommendations or actions that are the result of a review or hearing and appeal shall be monitored by the chief medical officer on an ongoing basis through the Ohio state university hospitals' quality management activities.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

3335-43-06 Hearing and appeal process.

(A) Right to hearing and to an appeal.

- (1) When a member of the medical staff who has exhausted all remedies under paragraphs (E) and (F) of rule 3335-43-04 of the Administrative Code on appointment or reappointments; or under rule 3335-43-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-43-05 of the Administrative Code, the staff member shall be entitled to an adjudicatory hearing.
- (2) A medical staff member shall not be entitled to a hearing under the following circumstances:
 - (a) Denial by the Wexner medical center board to grant a waiver of board certification for a medical staff member.
 - (b) Termination of a medical staff member because of exclusion from participation in

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- any government reimbursement program.
 - (c) Voluntary withdrawal of a medical staff application.
 - (d) Failure to submit a reappointment application.
 - (e) A leave of absence extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.
 - (f) Actions or recommendations resulting from an informal peer review.
 - (g) Termination of community affiliate C medical staff appointments upon approval by the Wexner medical center board.
- (3) All hearings and appeals shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.
- (B) Request for hearing.
- (1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief medical officer within thirty days of notification by the chief medical officer of the intended action. The chief medical officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.
 - (2) The failure of a medical staff member to request a hearing, to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the right to any review by the medical staff administrative committee. The chief medical officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Ohio state university Wexner medical center board as provided for in paragraph (F) of rule 3335-43-05 of the Administrative Code. The chief medical officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.
- (C) Notice of hearing.
- (1) After receipt of a timely request for hearing by the chief medical officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief medical officer and shall at the next scheduled meeting take the following action:
 - (a) Instruct the chief medical officer and chief of staff to jointly appoint within seven days a hearing committee, consisting of five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the formal peer review of the matter under consideration.
 - (b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty days nor more than sixty days from the date of the receipt of the request for hearing by the chief medical officer; provided, however, that a hearing for a medical staff member who is under suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.
 - (2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that this notice may be waived in writing by the medical staff member.

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Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

- (1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination.

The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than four members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

- (2) An accurate record of the hearing shall be kept. The mechanism for taking the record shall be by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the member's expense.
- (3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived all rights to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The medical staff administrative committee may, in its own discretion, order the hearing committee to proceed with the hearing without the medical staff member and impose a sanction which is greater or lesser than that originally imposed.
- (4) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.
- (5) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his or her

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own behalf, the staff member may be called and examined as if under cross-examination.

- (6) The hearing committee shall request the person who has taken the action from which the affected staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any parties witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written. The hearing committee may request legal representation from the Ohio state university.
- (7) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may elect to limit its proceedings when sufficient material has been received. The parties may be required by the hearing committee to provide evidence in oral or written form. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.
- (8) Within sixty days after its appointment, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation provided by the parties to the medical staff administrative committee. The affected medical staff member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.
- (9) The medical staff administrative committee shall submit a written report, including its recommendation to the chairperson of the Wexner medical center board within fourteen days of the final vote by the medical staff administrative committee. An adverse action which must be reported to the state medical board or the federal government, including the national practitioner data bank, shall entitle an affected medical staff member to the procedures of this rule. The affected member of the medical staff shall be notified of the decision of the medical staff administrative committee by the chief medical officer.
- (10) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee may accept, reject, or modify the decision of the medical staff administrative committee. The quality and professional affairs committee may remand that matter back to the medical staff administrative committee for further action as directed.
- (11) The recommendation of the quality and professional affairs committee shall be promptly considered by the Wexner medical center board, at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee. The Wexner medical center board may remand the matter

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back to the medical staff administrative committee for further action as directed.

- (12) A copy of the Wexner medical center board decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.

(E) Appeal process.

- (1) Within thirty days after receipt of a notice by an affected medical staff member of the decision of the medical staff administrative committee, the member may, by written notice to the chairperson of the Ohio state university Wexner medical center board, request an appeal. The appeal shall only be held on the record before the medical staff administrative committee.
- (2) If an appeal is not requested within thirty days, the affected medical staff member shall be deemed to have:
- (a) Waived the member's right to appeal, and
 - (b) Accepted the adverse decision.
- (3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.
- (4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the medical staff administrative committee. The staff member shall then submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee no later than seven days following the date of the affected member's notice of appeal.
- (5) New or additional matters not raised during the hearing or in the medical staff administrative committee hearings shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
- (6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.
- (7) Any final decision by the Wexner medical center board shall be communicated by the chief medical officer and by certified return receipt mail to the affected medical staff member at that member's last known address as determined by university records. The chief medical officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services, chief of staff, the chief of the clinical department, and the person(s) who initiated the request for formal peer review. The chief medical officer shall take immediate steps to implement the final decision.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018, 8/15/2023, 8/20/2024)

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3335-43-07 Categories of the medical staff.

The medical staff of the Ohio state university hospitals shall be divided into nine categories: attending, community affiliate A, community affiliate B, community affiliate C, community affiliate D, consulting, contracted, physician scholar and limited staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last ~~two~~three years and specific annual education requirements but are otherwise subject to the provisions of these bylaws.

(A) Attending.

- (1) Qualifications: The attending medical staff shall consist of those faculty members of the colleges of medicine and dentistry to whom clinical teaching responsibilities are assigned in the Ohio state university hospitals and who satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code. The assignment of teaching responsibility is the prerogative of the chief of the clinical department or the chief's designee.

- (2) Prerogatives.

An attending medical staff member may:

- (a) Admit patients consistent with their clinical privileges and the balanced teaching and patient care responsibilities of the Ohio state university hospitals. When, in the judgment of the chief of the clinical department, a balanced teaching program is jeopardized, following consultation with the dean of the college of medicine; and the Ohio state university hospitals' chief executive officer, and with the concurrence of a majority of the medical staff administrative committee, the chief of the clinical department may restrict an attending medical staff member's ability to admit patients. Imposition of such restrictions shall not entitle the attending medical staff member to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.
- (d) Hold office in the medical staff organization and in the clinical department and committees of which he or she is a member, unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

- (3) Responsibilities.

Each member of the attending medical staff with clinical privileges shall:

- (a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.
- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.

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- (c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such medical staff functions as may be required from time to time.
 - (d) Satisfy the requirements set forth in rule 3335-43-11 of the Administrative Code for attendance at staff and departmental meetings and meetings of those committees of which he or she is a member and for payment of membership dues.
 - (e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.
 - (f) Supervise other licensed healthcare professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed healthcare professional to perform only those services which the licensed healthcare professional is privileged to perform.
 - (g) Take call as assigned by the chief of the clinical department.
- (B) Community Affiliate A.
 - (1) Qualifications: The community affiliate A medical staff shall consist of physicians and other licensed healthcare professional who do not meet the criteria for attending medical staff appointment. This category includes community physicians and physicians employed by an affiliate entity who have clinical activity required for membership and actively participate in teaching programs.
 - (2) Prerogatives.

The community affiliate A medical staff may:

 - (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
 - (b) Admit, consistent with their clinical privileges, patients who complement the clinical teaching program.
 - (c) Attend meetings as a member of the medical staff and the clinical department of which he or she is a member and any medical staff or the Ohio state university hospitals education programs. The community affiliate A medical staff member may vote on medical staff policies, bylaws, rules and regulations and for elected officials of the medical staff. Members of the community affiliate A medical staff may be appointed to serve on medical staff committees as provided by these bylaws.
 - (3) Responsibilities: Each member of the community affiliate A medical staff with clinical privileges shall be required to have a faculty appointment and discharge the basic responsibilities specified in paragraph (B)(3) of this rule.
- (C) Community affiliate B.
 - (1) Qualifications: The community affiliate B medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are employed by an affiliate entity, do not have patient activity at university hospitals but who are enrolled under institutional managed care contracts or other contractual arrangements and who work at facilities not owned by the Wexner medical center. Community affiliate B medical

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staff members shall not be required to obtain appointment to the faculty of the Ohio state university and will not possess clinical privileges. Community affiliate B medical staff shall not be eligible to hold office or required to pay medical staff dues and shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws. Community affiliate B medical staff shall not be assigned to a clinical department under rule 3335-43-08 of the Administrative Code.

- (2) Appointment and reappointment: For purposes of processing applications for appointment and reappointment of community affiliate B medical staff, the duties of the chief of the clinical department set forth in rule 3335-43-04 of the Administrative Code shall be assigned by the chief medical officer to be performed by the chief physician of the affiliate entity or authorized designee. To perform these duties on behalf of community affiliate B medical staff, the chief physician or authorized designee must be an active member of the medical staff under these bylaws and will also serve as a voting member on the Medical Staff Administrative Committee.
- (3) Termination of medical staff membership: The medical staff membership of a community B affiliate physician shall automatically terminate upon loss of employment with the affiliate entity. This automatic termination shall not entitle the community B affiliate physician to any of the hearing processes set forth in rule 3335-43-06 of the Administrative Code.

(D) Community affiliate C.

- (1) Qualifications: The community affiliate C medical staff shall consist of those physicians and other licensed healthcare professionals who do not qualify for attending medical staff appointment and shall not possess clinical privileges. This category is comprised of referring physicians who desire to be associated with the Ohio state university hospitals to refer and follow patients. Community affiliate C medical staff members shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office and are not required to pay medical staff dues.
- (2) Prerogatives.

Community affiliate C medical staff members may:

- (a) Have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings.
- (b) Attend meetings as a member of the medical staff and the clinical departments of which he or she is a member and any medical staff or the Ohio state university hospitals education programs.
- (c) The grant of community affiliate C medical staff appointment to physicians is a courtesy only and may be terminated by the Wexner medical center board upon recommendation of the medical staff administrative committee without the right to a hearing or appeal.

(E) Community affiliate D.

This is a closed medical staff category that was created as a one-time historical category for medical staff members of the Ohio state university hospitals east prior to July 1, 2007.

- (1) Qualifications: Community affiliate D medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who:
 - (a) Do not qualify for an attending medical staff appointment; and

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- (b) Are community affiliate D members seeking reappointment; and
- (c) Satisfy the requirements and qualifications set forth in rule 3335-43-04 of the Administrative Code and are already appointed to the community affiliate D medical staff pursuant to these bylaws.
- (4) A community affiliate D medical staff member shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff. Community affiliate D medical staff members shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph. The community affiliate D medical staff member shall not be required to obtain appointment to the faculty of the Ohio state university. The community affiliate D medical staff member shall not be subject to the requirement for board certification within the community affiliate D medical staff member's respective area of practice if that requirement was waived when he or she became a member of the Ohio state university east medical staff. Teaching and research accomplishments shall not be required in determining the qualifications of applicants to this category of the medical staff.
- (5) To optimize the clinical organization, resource utilization, and planning of the hospitals, the chief of the clinical department may require that the applicant for community affiliate D medical staff membership to identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant which will be made a part of the application for appointment.
- (4) Prerogatives.

A community affiliate D medical staff member may:

- (a) Admit patients consistent with the limitations of bed and service allocations established by the medical directors and approved by the medical staff administrative committee, and the Wexner medical center board. If, in the judgment of the medical directors, a balanced teaching program is jeopardized, following consultation with the chief of the clinical department, and with the concurrence of a majority of the medical staff administrative committee, the medical director may restrict admissions of members of the community affiliate D medical staff. Patients admitted under the care of the community affiliate medical staff D will not be required to participate in the educational mission of the Ohio state university hospitals. Ordinarily, no coverage by the limited medical staff will be afforded, with the exception of emergency medical services.
- (b) Exercise the clinical privileges granted, have access to all medical records, and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.
- (c) Attend teaching and educational conferences approved by the Ohio state university, attend medical staff social functions, and participate as providers in the Ohio state university or the Ohio state university hospitals affiliated health plans.
- (5) Responsibilities.

Each member of the community affiliate D medical staff shall:

- (a) Participate in the management of and represent the interests of the clinical department for which he or she is granted clinical privileges. The community affiliate D medical staff member shall comply with all provisions of these bylaws and rules and regulations of the medical staff, unless expressly exempted under this rule.

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- (b) The community affiliate D medical staff member shall comply with all the Ohio state university hospitals' policies and accreditation standards, and shall be subject to the same quality evaluation, monitoring, and resource management requirements as other members of the medical staff.
 - (c) Be responsible within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.
 - (d) Not be eligible to vote on medical staff policies, rules and regulations, or bylaws or to hold office. Members of the community affiliate D medical staff may serve on non-elected medical staff committees as provided by these bylaws.
 - (e) Be subject to payment of medical staff dues or assessments as approved by the medical staff.
- (F) Consulting.
 - (1) Qualifications. The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:
 - (a) Satisfy the requirements and qualifications for membership set forth in rule 3335-04 of the Administrative Code.
 - (b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services at the Ohio state university hospitals only at the request of attending or community affiliate A members of the medical staff.
 - (c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the Ohio state university hospitals. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the Ohio state university hospitals. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.
 - (2) Prerogatives.

Consulting medical staff members may:

 - (a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or community affiliate A medical staff member.
 - (b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.
 - (c) Not admit patients to the Ohio state university hospitals.
 - (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.
 - (e) Must actively participate in such quality evaluation and monitoring activities as

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required by the medical staff and as outlined in the medical staff policy entitled "Consulting medical staff member policy."

- (f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.
- (g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as chief of a clinical department.
- (h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

- (a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.
- (b) Be exempt from all medical staff dues.

(G) Contracted.

- (1) Qualifications: contracted medical staff shall consist of those members who meet the requirements for medical staff membership and are providing services to Wexner medical center patients exclusively through a contract with the Wexner medical center. Contracted medical staff members shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff and shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph.

Contracted medical staff shall not be required to obtain appointment to the faculty of the Ohio state university. Contracted medical staff shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office or required to pay medical staff dues.

- (2) Prerogatives.

Contracted medical staff may:

- (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
- (3) Any contracted medical staff member whose membership has been terminated due to loss of contract and/or clinical privileges shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code.

(H) Physician scholar medical staff.

- (1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.
- (2) Prerogatives: Members of the physician scholar medical staff shall have access to the Ohio

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state university hospitals and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

- (3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(l) Limited staff.

Limited staff are not considered full members of the medical staff, do not have delineated clinical privileges and do not have the right to vote in general medical staff elections. Except where expressly stated, members of the limited staff are bound by the terms of these bylaws, the rules and regulations of the medical staff, and the limited staff agreement.

(1) Qualifications.

- (a) The limited staff shall consist of doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a post-doctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws.
- (b) The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state university Wexner medical center board, or the limited staff member's respective licensing board.
- (c) Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities.

Each member of the limited staff shall:

- (a) Be responsible to respond to all questions and to complete all forms as may be required by the credentials committee.
- (b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.
- (c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending or community affiliate A medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending or community affiliate A medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending or community affiliate A medical staff. The limited staff member shall follow all rules and regulations of the service to which the limited staff member is assigned, as well as the general rules of the Ohio state university hospitals pertaining to limited staff. Specifically, a limited staff member shall consult with the attending or

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community affiliate A member of the medical staff responsible for the care of the patient before the limited staff member undertakes a procedure or treatment that carries a significant, material-risk to the patient unless the consultation would cause a delay that would jeopardize the life or health of the patient.

- (d) Serve as a member of various medical staff committees in accordance with established committee composition as described in these bylaws and/or the rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization but may vote on committees to which the limited staff member is assigned.
 - (e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or sub-specialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical departmental chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.
 - (f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective department or training program and approved by the program director and the Ohio state university hospitals graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies. Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-43-05 and 3335-43-06 of the Administrative Code.
- (3) Failure to meet reasonable expectations.

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

- (4) Temporary appointments.
- (a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. These appointments shall not exceed sixty days.
 - (b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the medical directors, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

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(5) Supervision.

Limited staff members shall be under the supervision of an attending or community affiliate A medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending or community affiliate A medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending or community affiliate A medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or community affiliate A medical staff member or the director of the training program.

- (a) Limited staff members may write admission, discharge and other orders for the care of patients under the supervision of the attending or community affiliate A medical staff member.
- (b) All records of limited staff member cases must document involvement of the attending or community affiliate A medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(J) Temporary medical staff appointment.

- (1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.
- (2) Proctoring. Temporary privileges may be extended to visiting medical faculty for special clinical or educational activities as provided by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting physician may apply for temporary privileges per the prescribed medical staff proctoring policy.

(K) Clinical privileges.

(1) Delineation of clinical privileges.

- (a) Every person practicing at the Ohio state university hospitals by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed health care professional by the Ohio state university Wexner medical center board after recommendation from the medical staff administrative committee.

Each clinical department shall develop specific clinical criteria and standards for the evaluation of clinical privileges with emphasis on invasive or therapeutic procedures or treatment which present significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

- (b) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the

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forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such request must include documentation of relevant training or experience supportive of the request.

- (c) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the chief medical officer. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible the review should be of primary source information.
 - (d) The applicant shall have the burden of establishing the applicant's qualifications and competency in clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.
 - (e) The applicant's request for clinical privileges and the recommendation of the chief of the clinical department shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-43-04 of the Administrative Code.
 - (f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioners' professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.
 - (g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.
 - (h) Medical staff members authorize the Ohio state university hospitals and clinics to share credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the Ohio state university hospitals.
 - (i) Medical staff members authorize the Ohio state university hospitals to release information, in good faith and without malice, to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.
- (2) Temporary privileges.

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- (a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department. All temporary privileges are granted by the chief executive officer or authorized designee. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines.

Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.

- (b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental board.
 - (c) Temporary privileges granted for locum tenens may be exercised for a maximum of ninety days, consecutive or not, any time during the thirty-six month period following the date they are granted.
 - (d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.
 - (e) Special privileges. Upon receipt of a written request for specific temporary privileges and the approval of the clinical department chief and the chief medical officer, an appropriately licensed practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in these bylaws.
 - (f) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.
 - (g) The temporary and special privileges must be in conformity with accrediting bodies' standards and the rules and regulations of the professional boards of Ohio.
- (3) Expedited privileges.

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgement against the applicant or a challenge by a state licensing board.

(4) Podiatric privileges.

- (a) Practitioners of podiatry may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care that a podiatrist may provide

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without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

- (b) A member of the medical staff who is a doctor of medicine or osteopathy:
 - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and
 - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.
 - (c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.
 - (d) The podiatrist shall be responsible to the chief of the department of orthopaedics.
- (5) Psychology privileges.
- (a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise, unless otherwise authorized by law.
 - (b) Psychologists may not admit patients to the Ohio state university hospitals, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the Ohio state university hospitals.
- In outpatient settings, psychologists shall diagnose and treat their patients' psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.
- (c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.
- (6) Dental privileges.
- (a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy

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shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

- (b) A member of the medical staff who is a doctor of medicine or osteopathy:
 - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and
 - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.
- (c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.
- (7) Oral and maxillofacial surgical privileges.

All patients admitted to the Ohio state university hospitals for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

- (8) Other licensed health care professionals.
 - (a) Clinical privileges may be exercised by licensed health care professionals who are duly licensed in the state of Ohio, and who are either:
 - (i) Members of the faculty of the Ohio state university, or
 - (ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or
 - (iii) Employees or members of the medical staff.
 - (b) A licensed health care professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed health care professionals may perform all or part of the medical history and physical examination of a patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.
 - (c) Licensed health care professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-43-04 of the Administrative Code subject to the provisions of paragraph (G)(8) of this rule.
 - (d) Licensed health care professionals are not members of the medical staff, but may write admitting orders for patients of the Ohio state university hospitals when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed health care professionals and shall not be eligible to hold office, to vote on medical staff affairs,

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or serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

- (e) Each licensed health care professional shall be individually assigned to a clinical department and shall be sponsored by one or more members of the medical staff. The licensed health care professional's clinical privileges are contingent upon the sponsoring medical staff member's privileges. In the event that the sponsoring medical staff member loses privileges or resigns, the licensed health care professionals whom he or she has sponsored shall be placed on administrative hold until another sponsoring medical staff member is assigned. The new sponsoring medical staff member must be assigned in less than thirty days.
- (f) Licensed health care professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.
- (g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed health care professional:
 - (i) Current license, certification, or other legal credential required by Ohio law.
 - (ii) Certificate of authority, standard care agreement, or utilization plan.
 - (iii) Education, training, professional background and experience, and professional competence.
 - (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed health care professional subcommittee and the quality management department.
 - (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law.
 - (vi) Evidence of required immunization.
 - (vii) Evidence of good personal and professional reputation as established by peer recommendations.
 - (viii) Satisfactory physical and mental health to perform requested clinical privileges.
 - (xi) Ability to work with members of the medical staff and the Ohio state university hospitals employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the Ohio state university hospitals that any patient cared for by the licensed health care professional seeking clinical privileges shall be given quality care, and that the efficient operation of the Ohio state university hospitals will not be disrupted by the applicant's care of patients in the Ohio state university hospitals.
- (i) By applying for clinical privileges as a licensed health care professional, the applicant agrees to the following terms and conditions:
 - (i) The applicant has read the bylaws and rules and regulations of the medical

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staff of the Ohio state university hospitals and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable Ohio state university hospitals policies that the Ohio state university hospitals may from time to time put into effect.

- (ii) The applicant releases from liability all individuals and organizations who provide information to the Ohio state university hospitals regarding the applicant and all members of the medical staff, the Ohio state university hospitals staff, the Ohio state university Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant.
 - (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the Ohio state university hospitals.
 - (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed health care professional is a member of the medical staff.
 - (v) The applicant shall not perform any patient care in the Ohio state university hospitals that is not permitted under the applicant's license, certification, or other legal credential required under Ohio law.
 - (vi) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.
- (j) Licensed health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the chief quality officer or his or her designee. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, who may accept, reject, or modify the recommendation. The chief quality officer forwards his or her recommendation to the chief medical officer for final determination.
- (k) Appeal process.
 - (i) A licensed health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.
 - (ii) If an appeal is not so requested within the thirty-day period, the licensed health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the chief medical officer.
 - (iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed health care professional under review. The licensed health care professional under review shall have

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the opportunity to present any additional information deemed relevant to the review and appeal of the decision.

- (iv) The affected licensed health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review committee no later than seven days following the date of the licensed health care professional's notice of appeal.
 - (v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
 - (vi) Within thirty days following submission of the written statement by the licensed health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.
 - (vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed health care professional as determined by university records. The chief quality officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services and the chief of the applicable clinical department or departments. The chief medical officer shall take immediate steps to implement the final decision.
- (9) Emergency privileges.
- In case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the Ohio state university hospitals necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- (10) Disaster privileges.

Disaster privileges may be granted in order to provide voluntary services during a local, state, or national disaster in accordance with hospital/medical staff policy and only when the

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following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the chief medical officer or his or her designee to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the chief medical officer.

(11) Telemedicine privileges.

Practitioners who provide contracted patient care, treatment, and services via telemedicine shall be credentialed and privileged to provide such services. A grant of telemedicine privileges shall include appointment to the contracted medical staff category as described in paragraph (G) of this rule.

Practitioners providing contracted telemedicine services shall be credentialed and privileged through one of the following mechanisms:

- (a) The practitioner shall be credentialed and privileged in accordance with rule 3335-43-04.
- (b) The practitioner shall be credentialed and privileged by proxy using the credentialing and privileging decision from the distant site if all of the following requirements are met:
 - (i) The distant site is also accredited by the Joint Commission.
 - (ii) The distant site is a Medicare-participating hospital or a facility that qualifies as a distant-site telemedicine entity under federal regulations.
 - (iii) The Ohio state university hospitals have entered into a written agreement with the distant site.
 - (iv) If the distant site is a Medicare-participating hospital, the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the Centers for Medicare and Medicaid Services conditions of participation applicable to medical staff credentialing and privileging.
 - (v) If the distant site is a distant-site telemedicine entity as defined by federal regulations, the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Ohio state university hospitals and furnishes the contracted services in a manner that allows the Ohio State university hospitals Hospital to comply with all applicable Centers for Medicare and Medicaid Services conditions of participation for contracted services and for medical staff credentialing and privileging.
 - (vi) The individual distant-site practitioner is privileged at the distant site for those services to be provided to patients of the Ohio state university hospitals via telemedicine and the distant site provides a current list of the practitioner's privileges at the distant site.
 - (vii) The individual distant-site practitioner holds an appropriate license, telemedicine certificate, or telemedicine waiver issued by the applicable Ohio licensing board for the practitioner's area of practice.
 - (viii) The Ohio state university hospitals maintain documentation of all internal reviews of the performance of each distant-site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant-site Practitioner's privileges. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to patients of the Ohio state

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university hospitals, and all complaints the Ohio state university hospitals receive about the distant-site practitioner.

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3335-43-08 Organization of the medical staff.

- (A) Each member of the attending, community affiliate A, community affiliate C, community affiliate D, limited, and physician scholar medical staff shall be assigned to a clinical department and division, if applicable, upon the recommendation of the applicable chief of the clinical department.
- (B) Names of clinical departments.
 - (1) Anesthesiology.
 - (2) Dermatology
 - (3) Emergency medicine.
 - (4) Family and community medicine.
 - (5) Internal medicine.
 - (6) Neurological surgery.
 - (7) Neurology.
 - (8) Obstetrics and gynecology.
 - (9) Ophthalmology and visual science.
 - (10) Orthopaedics.
 - (11) Otolaryngology – head and neck surgery.
 - (12) Pathology.
 - (13) Pediatrics.
 - (14) Physical medicine and rehabilitation.
 - (15) Plastic and reconstructive surgery.
 - (16) Psychiatry and behavioral health.
 - (17) Radiation oncology.
 - (18) Radiology.

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- (19) Surgery.
- (20) Urology.
- (21) Dentistry.
- (C) The directors of the divisions in the Ohio state university hospitals shall be appointed by the chiefs of the clinical departments in the Ohio state university hospitals in which the divisions are included.
- (D) Qualifications and responsibilities of the chief of the clinical department.

The academic department chairperson shall ordinarily serve also as the chief of the clinical department. Each chief of the clinical department shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each chief of the clinical department must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the college of medicine or dentistry. Qualifications for chief of the clinical department generally shall include: recognized clinical competence, sound judgment and well-developed administrative skills.

- (1) Procedure for appointment and reappointment of the chief of the clinical department.

Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective college of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer.

- (2) Term of appointment of the chief of the clinical department.

The term of appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(1) of this rule.

- (3) Duties of the chief of the clinical department.

Each chief of the clinical department is responsible for the following:

- (a) Clinically related activities of the department;
- (b) Administratively related activities of the department, unless otherwise provided by the hospital;
- (c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;
- (d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;
- (f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the

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hospital;

- (g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;
- (h) The coordination and integration of interdepartment and intradepartmental services;
- (i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;
- (j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including ensuring that call coverage provides for continuous high quality and safe care;
- (k) The determination of the qualifications and competence of department or service personnel who are not licensed practitioners and who provide patient care, treatment, and services;
- (l) The continuous assessment and improvement of the quality of care, treatment, and services;
- (m) The maintenance of quality control programs, as appropriate;
- (n) The orientation and continuing education of all persons in the department or service;
- (o) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of departmental meetings, including a record of attendance, shall be electronically available and/or distributed to all medical staff members in the clinical department, and such minutes shall be kept in the clinical department.

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3335-43-09 Elected officers of the medical staff of the Ohio state university hospitals.

(A) Chief of staff.

The chief of staff shall:

- (1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of that board.
- (2) Serve as vice chairperson of the medical staff administrative committee.
- (3) Provide for communication between the medical staff and the Ohio state university Wexner medical center board or its committees in matters of quality of care, education, and research.

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- (4) Serve as liaison between the Ohio state university hospitals administration, medical administration, and the medical staff in all matters of mutual concern within the Ohio state university hospitals.
 - (5) In consultation with the medical directors and the chief medical officer, seek to ensure that the medical staff is represented and participates as appropriate in any Ohio state university hospitals deliberation which affects the discharge of medical staff responsibilities.
 - (6) Call, preside, and be responsible for the agenda of all general medical staff meetings.
 - (7) Make medical staff committee appointments in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code.
 - (8) Be spokesperson for the medical staff in its external professional and public relations.
 - (9) Serve as chairperson of the nominating committee of the medical staff.
- (B) Chief of staff-elect.
- The chief of staff-elect shall:
- (1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.
 - (2) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.
 - (3) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.
 - (4) Assist the Chief of Staff with duties outlined above in paragraph (A)(1) to (A)(9).
- (C) Representatives of the medical staff elected at-large.
- There shall be six medical staff representatives elected at-large. Each representative shall be a member of the medical staff administrative committee and shall serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.
- (D) Qualifications of officers.
- (1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved.
 - (2) Chiefs of the clinical departments shall not be eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their Ohio state university hospitals administrative role during the period of their term of office.
- (E) Election of officers.
- (1) All officers (other than at-large officers) shall be elected by a majority of those voting by electronic ballot of the attending staff.
 - (2) The nominating committee shall be composed of five members. The chief of staff shall serve on the committee and shall select four other members for the committee. The chief of staff shall be its chairperson.

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- (3) Nominations for officers shall be accepted from any member of the medical staff and shall be submitted either electronically or in writing to the nominating committee.
 - (4) The committee's nominees shall be submitted to all voting members of the attending staff no later than May first of the election year.
 - (5) Candidates for the office of chief of staff-elect shall be listed and each attending staff member shall be entitled to cast one vote. Candidates for the at-large positions shall be voted upon as a group. Each voting member of the attending staff shall be entitled to vote for three at-large candidates. The three candidates with the highest number of votes shall be elected. A majority of the votes shall not be necessary.
 - (6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the Ohio state university Wexner medical center, its goals and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.
- (F) Term of office.
- (1) The chief of staff and chief of staff-elect shall each serve two years in office beginning on July first. The chief of staff-elect shall be elected in the odd numbered years. A former chief of staff may not succeed the immediately preceding chief of staff-elect.
 - (2) The at-large representatives shall each serve two years, beginning July first. The at-large representatives may succeed themselves for three successive terms (six years total), if so elected. Upon completion of the three successive terms, the representative may not serve again without a period of two years out of office as an at-large representative. The representative may be elected chief of staff-elect at any time.
- (G) Vacancies in office.
- (1) A vacancy in the office of chief of staff shall be filled by the chief of staff-elect. If the unexpired term is one year or less, the new chief of staff shall serve out the remaining term in office and shall then serve as chief of staff for the term for which elected. If the unexpired term is more than one year, the new chief of staff shall serve out the remaining term only.
 - (2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The new chief of staff-elect shall become chief of staff at the end of the term of the incumbent.
 - (3) Vacancies in the at-large representatives medical staff positions shall be filled by appointment by the chief of staff.

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3335-43-10 Administration of the medical staff of the Ohio state university hospitals

(A) Chief medical officer.

The chief clinical officer functions as the chief medical officer as referred to herein these bylaws. The chief medical officer is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is

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responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state university Wexner medical center board bylaws.

(B) Chief quality officer.

The chief quality and patient safety officer of the Ohio state university Wexner medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer. The chief quality officer works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(C) Medical directors.

The medical directors of the hospitals of the Ohio state university report to the chief executive officer or the executive director of the respective hospital and chief medical officer. Each medical director will collaborate with the chief quality officer, the chief medical officer and the clinical department chiefs to develop, execute and monitor the quality and safety programs of the hospital. The appointment, scope of authority, and responsibilities of the medical directors for the Ohio state university hospitals shall be further outlined in the Ohio state university Wexner medical center board bylaws.

(D) Medical staff committees.

(1) Appointments:

Appointments to all medical staff committees except the medical staff administrative committee, nominating committee and all health system committees, shall be made jointly by the chief of staff, chief of staff-elect, and the hospital medical directors with medical staff administrative committee ratification. Representatives from the Ohio state university hospitals to health system committees shall be appointed jointly by the chief medical officer of the health system and the medical director. Unless otherwise provided by these bylaws, all appointments to medical staff committees shall be for two years and may be renewed. The chief of staff, chief medical officer, medical director, and the chief executive officer of the Ohio state university hospitals may serve on any medical staff committee as an ex-officio member without vote.

(2) Meetings:

Each medical staff committee shall meet at the call of its chairperson and at least quarterly. Committees shall maintain records of proceedings and minutes of meetings and shall forward all recommendations and actions taken to the chief medical officer who shall promptly communicate them to the medical staff administrative committee. The chairperson shall control the committee agenda, attendance of staff and guests, and conduct of the proceedings. A simple majority of appointed voting members shall constitute a quorum.

(3) Peer review committees:

The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and/or monitoring the quality and utilization of patient care services provided by

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the Ohio state university hospitals.

(E) Medical staff administrative committee.

(1) Composition.

- (a) This committee shall consist of the following voting members: chief of staff, chief of staff-elect, chiefs of the clinical departments, chief physician for the affiliated entity employing community affiliate B medical staff, six medical staff representatives elected at large, the chief medical officer, and the chief executive officer of the Ohio state university hospitals or designee. Additional members may be appointed to the medical staff administrative committee at the recommendation of the dean or the chief medical officer of the medical center subject to the approval of the medical staff administrative committee and subject to review/renewal on a biennial basis. Any members may be removed from the medical staff administrative committee at the recommendation of the dean, the executive vice president for health sciences or the chief medical officer of the medical center and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's constituency. The chief medical officer shall be the chairperson and the chief of staff shall be vice-chairperson.
- (b) Any member of the committee who anticipates absence from a meeting of the committee may appoint as a temporary substitute another member of the same category of the medical staff to represent him or her at the meeting. The temporary substitute shall have all the rights of the absent member.
- (c) All members of the committee shall attend, either in person, virtual, or by proxy, a minimum of two-thirds of all committee meetings.

(2) Duties.

- (a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws, by the bylaws of the Ohio state university Wexner medical center board, the bylaws or rules of the board of trustees of the Ohio state university.
- (b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to section 3335-43-13 of these bylaws.
- (c) To receive and act upon committee reports.
- (d) To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.
- (e) To approve and implement policies of the medical staff.
- (f) To provide a liaison between the medical staff, medical director, chief executive officer, and the Wexner medical center board.
- (g) To recommend action to the medical directors and chief executive officer of the Ohio state university hospitals on matters of medical-administrative nature.

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- (h) To fulfill the medical staff's accountability to the Wexner medical center board and the board of trustees of the Ohio state university for medical care rendered to patients in the Ohio state university hospitals, and for the professional conduct and activities of the medical staff, including recommendations concerning:
 - (i) Medical staff structure;
 - (ii) The mechanism to review credentials and to delineate clinical privileges;
 - (iii) The mechanism by which medical staff membership may be terminated;
 - (iv) Participation in the Ohio state university hospitals' performance improvement activities; and
 - (v) Corrective action and hearing procedures applicable to medical staff members and other licensed health care professionals granted clinical privileges.
 - (vi) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the Ohio state university hospitals.
 - (i) To review and act on medical staff appointments, reappointments, and requests for delineation of clinical privileges. Whenever there is doubt of an applicant's ability to perform the privileges requested, the medical staff administrative committee shall have the authority to request an evaluation of the applicant's clinical activities relevant to requested privileges.
 - (j) To report to the medical staff all actions affecting the medical staff.
 - (k) To inform the medical staff of all changes in committees, and the elimination of such committees as circumstances shall require.
 - (l) To create committees (for which membership is subsequently appointed pursuant to rule 3335-43-09 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.
 - (m) To establish and maintain rules and regulations governing the medical staff.
 - (n) To perform other functions as are appropriate.
- (3) Executive session.
- (a) Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.
- (4) Meetings. The committee shall meet monthly and shall keep detailed minutes which shall be distributed to each committee member and to the Wexner medical center board through the quality and professional affairs committee.
- (5) Voting. At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership

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or permanent suspension of clinical privileges, wherein a two-thirds vote of members present shall be required.

(F) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition.

The credentialing responsibilities of medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each health system hospital.

The credentialing committee of the hospitals of the Ohio state university shall be appointed by the chief medical officer of the health system. The chief of staff, director of medical affairs and medical directors of each hospital shall make recommendations to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, who shall be appointed by the chief medical officer of the health system.

(2) Duties.

- (a) To review all applications for medical staff and licensed health care professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;
- (b) To review triennially all applications for reappointment or renewal of clinical privileges;
- (c) To review all requests for changes in medical staff membership;
- (d) To assure, through the chairperson of the committee, that all records of formal peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;
- (e) To make recommendations to the medical staff administrative committee through the chairperson of the credentialing committee regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;
- (f) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;
- (g) The committee, after review and investigation, may make recommendations to the chief medical officer, chief of staff or the chief of a clinical department, regarding the restriction or limitation of a member's clinical privileges for noncompliance or any

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other matter related to its responsibilities;

- (h) To review all grants of special or temporary privileges; and
 - (i) To review requests made for clinical privileges by other licensed health care professionals as set forth in these bylaws.
 - (j) To recommend eligibility criteria for the granting of medical staff membership and privileges.
 - (k) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.
 - (l) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.
 - (m) To perform such other functions as requested by the medical staff administrative committee, the quality and professional affairs committee or Wexner medical center board.
- (3) Licensed health care professionals subcommittee.
- (a) Composition.

This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code. The subcommittee shall be chaired by a director of nursing who shall serve as chair of the subcommittee.
 - (b) Duties.
 - (i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university.
 - (ii) To review and investigate the character, qualifications and professional competence of the applicant.
 - (iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal.
 - (iv) To verify the accuracy of the information contained in the application.
 - (v) To request a personal interview with the applicant if deemed appropriate.
 - (vi) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.
 - (vii) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed health care professional specialty. These policies and procedures shall be ratified by the credentialing committee and medical staff administrative committee, and be approved by the Wexner medical center board.

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(G) Committee for practitioner health.

(1) Composition.

The committee shall consist of medical staff members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code.

(2) Duties.

- (a) To consider issues of licensed practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, the Ohio state university hospitals staff, or any other individual.
- (b) To educate the medical staff and the Ohio state university hospitals staff about illness and impairment recognition issues, including at-risk criteria, specific to licensed practitioners.
- (c) To provide appropriate counsel, referral and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.
- (d) To consult regularly with the chief of staff, chief medical officer and medical director of the Ohio state university hospitals.
- (e) To advise credentials or other appropriate medical staff committees on the credibility of any complaint, allegation or concern, including those affecting the quality and safety of patient care.
- (f) To assure, through the chairperson of the committee, that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest confidence in accordance with the laws of the state of Ohio.
- (g) To initiate appropriate actions when a licensed practitioner fails to complete the required rehabilitation program.

(H) Medical staff bylaws committee.

(1) Composition.

The committee shall consist of those members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code. The chairperson shall always be the chief of staff-elect.

(2) Duties.

- (a) To review and recommend amendments, as appropriate, to these medical staff bylaws to the medical staff administrative committee at least every two years.
- (b) To receive from members of the medical staff or the medical staff administrative committee any suggestions that may necessitate amendment of these bylaws.

(I) Infection prevention committee.

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(1) Composition.

The medical staff members of the committee shall consist of those members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code. The committee shall also include representatives of nursing, environmental services, and hospital administration as may be invited from time to time by the chief of staff. The chairperson shall be a physician member of the medical staff with experience or training in infectious diseases.

(2) Duties.

- (a) To oversee surveillance and institute any recommendations necessary for the investigation, prevention, containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities owned, operated, or controlled by the Ohio state university hospitals and subject to JCAHO standards.
- (b) To take necessary action through the chairperson of the committee, and the Ohio state university hospitals' epidemiologist, in consultation with the medical director of the Ohio state university hospitals, to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

(J) Ethics committee.

(1) Composition.

The committee shall consist of members of the medical staff, nursing, hospital administration, and other persons who by reason of training, vocation, or interest may make a contribution. Members shall be appointed as provided in these bylaws. The chairperson shall be a medical staff member who is a clinically active physician.

(2) Duties.

- (a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.
- (b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the Ohio state university hospitals.
- (c) To provide a support mechanism for primary decision makers at the Ohio state university hospitals.
- (d) To provide educational resources on ethics to all health care providers at the Ohio state university hospitals.
- (e) To provide and enhance interaction between hospitals administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(K) Practitioner evaluation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the

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assistance from any medical staff member or recommend to the chief medical officer an external review.

(2) Duties.

- (a) To meet and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer and chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and operations improvement office.
- (b) To ensure that ongoing and systematic monitoring, evaluation, and process improvement is performed in each clinical department.
- (c) To develop and utilize objective criteria in practitioner peer review activities.
- (d) To ensure that the medical staff peer review process is effective.
- (e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of PEC by any individual, clinical department, division, or committee.

(L) Quality Leadership Council.

(1) Composition.

The quality leadership council shall consist of members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code, and shall include the executive vice president for health sciences, the dean of the college of medicine and the chairperson of the quality and professional affairs committee of the Wexner medical center board as ex-officio members without a vote. The chief quality officer shall be the chairperson of the quality leadership council.

- (a) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery system.
- (b) To serve as the oversight council for the clinical quality management and patient safety plan.
- (c) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(M) Clinical quality and patient safety committee.

(1) Composition.

The members of this group shall be appointed pursuant to these bylaws and shall include medical staff members from various clinical departments and support services, and shall include the director of the clinical quality management policy group, and representatives of nursing and hospitals administration. The chairperson of the policy group shall be a physician member of the medical staff.

(2) Duties.

- (a) To coordinate the quality management related activities of the clinical departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and isoimmunization, and other medical staff and the Ohio state university hospitals committees.

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- (b) To implement clinical improvement programs to achieve the goals of the Ohio state university hospitals quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.
 - (c) To review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.
 - (d) To serve as liaison between the Ohio state university and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.
 - (e) To make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the Ohio state university hospitals.
 - (f) To hear and determine issues concerning the quality of patient care rendered by members of the medical staff and the Ohio state university hospitals staff and make appropriate recommendations and evaluate action plans when appropriate to the chief medical officer, the medical director, the chief of a clinical department, or the Ohio state university hospitals administration.
 - (g) To appoint ad-hoc interdisciplinary teams to address the Ohio state university hospitals-wide quality management plan.
 - (h) To annually review and revise as necessary the Ohio state university hospitals-wide clinical quality management plan.
 - (i) To report and coordinate with the quality leadership council all quality improvement initiatives.
- (N) Utilization management committee.
 - (1) Composition.

The members shall be appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code and shall include medical staff members from various clinical departments and support services the directors of clinical quality and case management, and representatives of nursing and hospitals administration. The chairperson of the committee shall be a physician member of the medical staff.
 - (2) Duties.
 - (a) To promote the most efficient and effective use of the hospitals of the Ohio state university health system facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.
 - (b) To formulate and maintain a written resource management review plan for the hospitals of the Ohio state university health system consistent with applicable governmental regulations and accreditation requirements.
 - (c) To conduct resource management studies by clinical department or divisions, or by disease entity as requested or in response to variation from benchmark data would indicate.

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- (d) To report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements, and when the opportunity exists to improve the resource management.
 - (e) To oversee evaluation and cost effective utilization of clinical technology.
 - (f) To oversee the activities of the utilization management committee of the hospitals of the Ohio state university health system. This oversight will include the annual review and approval of the utilization management plan.
- (O) Clinical practice guideline committee.
 - (1) Composition.

The members shall be appointed in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code, and shall include medical staff members from various clinical departments and support services, representatives of nursing, pharmacy, information systems, hospitals administration, and the chair of the clinical quality and management policy group. The chairperson of the policy group shall be a physician member of the medical staff.
 - (2) Duties.
 - (a) To oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e., clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the Ohio state university hospitals and its affiliated institutions. Planning should be based on the prioritization criteria approved by the quality leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guideline.
 - (b) To report and recommend to quality leadership council specific process and outcomes measures for each evidence-based medicine resource.
 - (c) To oversee ongoing education of medical staff (including specifically limited staff) and other appropriate Ohio state university hospitals staff regarding the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.
 - (d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.
 - (e) To oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the Ohio state university hospitals and its affiliated institutions. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to quality leadership council for approval. All other computerized ordersets and clinical rules should be forwarded to the quality leadership council for information.
 - (f) To regularly report a summary of all actions to the quality leadership council.
- (P) Committee for practitioner effectiveness.

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(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

- (a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;
- (b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;
- (c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;
- (d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;
- (e) Forward all recommendations to the clinical department chief, the chief medical officer or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 4/7/2000, 10/5/2001, 6/7/2002, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 4/8/2011, 8/31/2012, 2/01/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021, 8/15/2023, 8/20/2024)

3335-43-11 History and physical

(A) History and physical examination.

- (1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:
 - (a) Admitted to the hospital
 - (b) Undergoing outpatient/ambulatory procedures requiring anesthesia or sedation
 - (c) Undergoing outpatient/ambulatory surgery
 - (d) In a hospital-based ambulatory clinic
- (2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:
 - (a) Date of admission
 - (b) History of present illness, including chief complaint
 - (c) Past medical and surgical history
 - (d) Relevant past social and family history
 - (e) Medications and allergies
 - (f) Review of systems

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- (g) Physical examination
 - (h) Test results
 - (i) Assessment or impression
 - (j) Plan of care
- (3) For patients undergoing outpatient/ambulatory procedures requiring anesthesia or sedation or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:
 - (a) Indications for procedure or surgery
 - (b) Relevant medical and surgical history
 - (c) Medications and allergies or reference to current listing in the chart or electronic medical record
 - (d) Focused review of systems, as appropriate for the procedure or surgery
 - (e) Pre-procedure assessment and physical examination
 - (f) Assessment/impression and treatment plan
- (4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:
 - (a) Chief complaint
 - (b) History of present illness
 - (c) Medications and allergies
 - (d) Problem-focused physical examination
 - (e) Assessment or impression
 - (f) Plan of care
- (5) Deadlines and sanctions.
 - (a) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and be signed, timed and dated.
 - (b) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.
 - (c) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.
 - (d) Admitted patients or patients undergoing a procedure requiring anesthesia or

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sedation or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery. If completed before admission or the procedure/surgery, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, timed and dated by the responsible medical staff member.

- (i) For patients undergoing an outpatient procedure requiring anesthesia or sedation or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.
 - (ii) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.
- (e) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.
- (f) When the history and physical examination, including the results of indicated laboratory studies and x-rays, is not recorded in the medical record before the time stated for a procedure or surgery, the procedure or surgery cannot proceed until the history, and physical is signed or countersigned when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is a disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee. (B/T 10, 29/2009, 8/31/12)
- (g) Ambulatory patients must have a history and physical at the initial visit as outlined in paragraph (A)(4) of this rule.
- (h) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:
 - i. within the past six months prior to the initial visit,
 - ii. at the initial visit, or
 - iii. within 30 days following the initial visit.

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(Board approval dates: 10/29/2009, 8/31/2012, 1/31/2014, 11/7/2014, 11/6/2015, 8/20/2024)

3335-43-12 Meetings and dues.

(A) Meetings.

The medical staff of the Ohio state university hospitals shall conduct scheduled meetings at least annually. Notice of the meeting shall be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special and/or electronic meetings of the medical staff may be called at the option of the medical staff administrative committee.

(B) Dues.

The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued staff membership.

(Board approval date: 10/29/2009, 4/6/2018, 8/15/2023)

3335-43-13 Amendments and adoption.

(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations, and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

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In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment, it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five per cent of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via secure ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least fourteen days advance notice of the changes to be adopted:

- (1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.
- (2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rule, regulation, or policy by submitting a petition signed by twenty-five percent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

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The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval date: 4/8/2011, 11/7/2014, 8/15/2023)

3335-43-14 Rules of construction.

- (A) "Shall" as used herein is to be construed as mandatory.
 - (B) These bylaws should be construed to be gender neutral.
- (Effective 6/14/2011 no board date given; was not 4/8/2011)

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APPENDICES

APPENDIX I. COAT OF ARMS OF
THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of The Ohio State University Hospitals shall be as follows:

The blazon of the arms of University Hospitals is a shield, 16th century style, on a field of gray surrounded by an "O" in scarlet with the words, "The Ohio State University Hospitals" in black.

The shield is embattled above the chief, with three azure towers. The shield is divided "fesse cotised," through the "fesse point" by three bars, "gemels of or" (gold), separated each by bars, "gemels of argent" (silver). The chief is "gules" (scarlet), impaled by a charge, "The Ohio State University Crest." The "O" is argent, the center is gules, impaled by a charge with the "or" book of knowledge, and the base of the "O" is impaled by a charge of a "buckeye leaf vert" (green).

The base is quartered per pale.

The dexter base is vertical with a charge, the staff of Aesculapius.

The sinistra base is azure with a charge, the Hospitalier's cross, gules.

The scroll contains the Latin motto: "Hospitale-Academia-Investigatus."

The use of the coat of arms of The Ohio State University Hospitals will be by all who are connected with University Hospitals.

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APPENDIX II.

COAT OF ARMS OF THE MEDICAL STAFF
OF THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of the medical staff of The Ohio State University Hospitals shall be as follows: The shield on vertical narrow stripes, alternating silver and white, is square, parted per green (medicine) chevron. The dexter chief contains the golden oak leaf surmounted by the silver acorn representing the practice of medicine; the sinistra chief contains the multiple atomis circles representing research; the center base contains the golden book of knowledge encircled by the gray "O" from the crest of The Ohio State University and represents the teaching obligation of our staff. The scroll is gold, with the black lettering of the motto, "Eruditio A Scientia Exornata Miliorem Valetudinem Mortalibus Praestat" (knowledge enhanced by science assures better health for mankind).

Encircling the achievement are the words, "The Medical Staff" joined by a green buckeye leaf (symbol of the State of Ohio) to the words, "The Ohio State University Hospitals." Impaled in this "coat of arms" are the heritage of the State of Ohio and The Ohio State University with the obligation of teaching and research to provide and improve medical care. The use of this coat of arms of the medical staff shall be limited to duly appointed members of the medical staff and the staff organization.

ATTACHMENT XXXIX

Joint Bylaws Committee Meeting University Hospitals and The James

August 21, 2025

Summary of Proposed Amendments

The James Bylaws

- Proposed changes to 3335-43-04 (Membership) and 3335-111-07 (Categories of the medical staff) describing the required period of active clinical practice from “two” years to “three” to bring in-line with current recredentialing cycles.
- Proposed addition of Contracted medical staff category in 3335-111-07(G) to align with Contracted medical staff category in University Hospitals Bylaws and to align with current workflow of Corporate Credentialing.
- Proposed addition of granting telemedicine privileges by proxy as permitted by Centers for Medicare and Medicaid Services Conditions of Participation and by Joint Commission standards – added at 3335-111-07(K)(11).
- Removal of outdated telemedicine privilege language in same paragraph. Telemedicine privileges for health system employed providers are now addressed on delineation of privilege forms.

The James Rules and Regulations

- Proposed deletion of “as verified by the attending medical staff member’s signature” from Rule 10 (Medical records) at paragraph (A)(1)(a)(xii)(d) to remove this additional requirement that is not present in UH bylaws.



**Chapter 3335-111 - Bylaws of the Medical Staff of the
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

Updated July 25, 2025

3335-111-01 Medical staff name.

The board of trustees of the Ohio state university, by official action, established "the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI)." Hereinafter, the abbreviation "CHRI" shall mean the Arthur G. James cancer hospital and Richard J. Solove research institute; the term "medical staff" shall refer to the medical staff of the cancer hospital and research institute. "The medical staff of the Arthur G. James cancer hospital and Richard J. Solove research institute" shall be the name of the hospital's medical staff organization. In accordance with rules 3335-109-01 to 3335-109-20 and 3335-104-07 of the Administrative Code, the Ohio state university Wexner medical center board (herein called "Wexner medical center board") has delegated to the medical staff of the CHRI the responsibility to prepare and recommend adoption of these bylaws.

(Board approval dates: 9/1/1993, 2/5/1999, 9/6/2002, 2/6/2004, 11/4/2005, 2/11/2011, 11/7/2014)

3335-111-02 Purpose.

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state medical center board for the quality of care provided to the patients of the CHRI shall be:

- (A) To maintain exemplary standards of medical care for all patients at the CHRI. To assure continuity of care and treatment for the individual patient throughout the course of his or her illness, and to assure ongoing support and care for cancer survivors. To commit to being responsive to the needs of all CHRI patients and to communicate compassionately and effectively concerning matters of patient care.
- (B) To support and encourage research, with an emphasis on the prevention and treatment of cancer; to actively encourage patients to participate in clinical trials and other research, and to foster research programs to enhance and advance the educational and patient care programs.
- (C) To support educational programs for health care and other professionals, patients and families, and the community, with an emphasis on cancer-related education; to elevate and advance the educational standards of our professions, including pre and post medical or osteopathic students, nursing students, students of the allied medical professions, and students of other health professional colleges.
- (D) To provide a means to identify and review medical problems, assure adherence to regulatory and accreditation standards, review and revise policies and procedures; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, evaluation and discipline within the medical staff, and harmonious cooperation and understanding among the units comprising the CHRI.
- (E) To govern medical staff credentialed practitioners and these Bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 11/4/2005, 9/18/2009, 10/29/2011, 4/8/2011, 4/6/2018)

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3335-111-03 Patients.

- (A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, associate attending, clinical attending or community associate attending medical staff to whose care the patient is treated at or transferred to the CHRI, and to an allied health professional being granted clinical privileges under these bylaws.
- (B) There shall be only one category or classification of patients in the CHRI, and those patients are the patients of the medical staff under whose care they are treated. Patients treated at the CHRI who, prior to treatment, have not requested or selected a member of the medical staff to attend them shall be assigned for their care and treatment to a member of the medical staff for their care and treatment.
- (C) All patients treated at the CHRI should cooperate in, and, whenever applicable, participate in an approved cancer related protocol and knowingly participate in the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the CHRI or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patients representative, of their right to refuse participation.
- (D) Students, including pre and post medical or osteopathic, but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned for treatment within the CHRI. The CHRI respects the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's rights to refuse care, treatment and services, in accordance with law and regulation.

(Board approval dates: 9/1/1993, 12/6/1996, 12/3/1999, 9/6/2002, 2/6/2004, 11/4/2005, 9/18/2009, 4/8/2011)

3335-111-04 Membership.

- (A) Qualifications.
 - (1) Membership on the medical staff of the CHRI is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, genetic information or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same policies and procedures as all other applicants for the medical staff.
 - (2) All members of the medical staff of the CHRI, except physician scholar medical staff, shall be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the respective state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of

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their profession, dedication to educational and research goals and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at the CHRI will be given high quality medical care provided at CHRI, shall be qualified for eligibility for membership on the medical staff of the CHRI. CHRI medical staff members shall also hold appointments to the medical staff of the Ohio state university hospitals for consulting purposes. Loss of such appointment shall result in immediate termination of membership on the CHRI medical staff and immediate termination of clinical privileges as of the effective date of the Ohio state university hospitals appointment termination. This consequence does not apply to an individual's suspension for completion of medical records. If the medical staff member regains an appointment to the Ohio state university hospitals medical staff, the affected medical staff member shall be eligible to apply for CHRI medical staff membership at that time. All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The director of medical affairs of the CHRI, the medical director of credentialing, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant.

- (3) All members of the medical staff and licensed health care professionals will comply with medical staff and the CHRI policies regarding employee and medical staff health and safety, provision of uncompensated care, and will comply with appropriate administrative directives and policies which, if not followed, could adversely impact overall patient care or may adversely impact the ability of the CHRI employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety. Annual education and training approved by the medical staff administrative committee or as required by the CHRI to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosures. Medical staff members and licensed health care professionals must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.
- (4) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental healthcare programs. This includes any federal and state government programs.
 - (a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental program.
 - (b) Exclusion of any medical staff member or credentialed provider from participation in any federal or state government program or suspension from participation, in whole or in part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the CHRI and the immediate

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lapse of clinical privileges at the CHRI as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

- (c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.
- (5) Board certification.

An applicant for membership shall at the time of appointment or reappointment, be board certified in his or her specialty. This board certification must be approved by the American board of medical specialties, or other applicable certifying boards for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirement. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in termination of membership on the medical staff of the CHRI.
- (6) All applicants must demonstrate recent clinical activity in their primary area of practice during the last twothree years to satisfy minimum threshold criteria for privileges within their clinical departments.
- (7) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(4) to (A)(6) of this rule may be requested and considered as follows:
 - (a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden to demonstrate that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.
 - (b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant clinical department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.
 - (c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

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- (d) The Wexner medical center board determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a denial of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted.
- (e) Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.
- (f) Waivers to requirements prescribed by regulatory, accrediting, or other external agencies will not be granted.
- (8) Resignation, termination or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the CHRI for attending, associate attending and clinical attending staff members.
- (9) Any staff member whose membership has been terminated pursuant to paragraph (A)(4) or (A)(5) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-111-06 of the Administrative Code. Any allied health professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph (J)(8)(i) of rule 3335-111-07 of the Administrative Code.
- (10) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.

(B) Application for membership.

Initial application for all categories of medical staff membership shall be made by the applicant to the clinical department chief or designee on forms prescribed by the medical staff administrative committee, stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the qualifications are fulfilled as outlined in paragraph (A) of this rule. See paragraph (E)(1) of rule 3335-111-07 of the Administrative Code for exceptions to signature requirements. The application shall include written statements by the applicant that commit the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant for medical staff membership shall agree that membership requires participation in and cooperation with the peer review processes of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in these review processes as long as the peer review is not conducted in bad faith, with malice, or without reasonable effort to ascertain the accuracy of information being disclosed or relied upon. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed thirty-six months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. During the first six months of the initial appointment, except medical staff appointments without clinical privileges, appointees shall be subject to focused

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professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by the clinical department chief with oversight by the credentials committee and the medical staff administrative committee.

The provisional appointee identifies the primary hospital. Following the six month FPPE period, the clinical department chief may:

- (1) recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee;
- (2) extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a total of twelve months for purposes of further monitoring and evaluation; or
- (3) terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

(D) Professional ethics.

The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American osteopathic association, the American psychological association, the American college of surgeons, or the American podiatric medical association shall usually govern the professional ethical conduct of the respective members of the medical staff.

(E) Procedure for appointment.

- (1) The completed and signed application for membership of all categories of the medical staff as defined in rule 3335-111-07 of the Administrative Code, shall be presented to the clinical department chief or designee. The applicant shall include in the application a signed statement indicating the following:
 - (a) If the applicant should be appointed to a category of the CHRI medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of the trustees of the Ohio state university.
 - (b) The applicant consents to be interviewed in regard to the application.
 - (c) The applicant authorizes the CHRI to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.
 - (d) The applicant consents to the CHRI's inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges which the applicant is seeking as well as the applicant's professional and ethical qualifications for medical staff membership.
 - (e) The applicant releases from any liability:

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- (i) All representatives of the CHRI for acts performed in connections with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith and without malice; and
 - (ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the CHRI staff, the medical center board members, and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith and without malice.
 - (f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
 - (g) The applicant further agrees to disclose to the director of medical affairs or the medical director of credentialing the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
 - (h) The applicant agrees that acceptance of an appointment to any category of the CHRI medical staff authorizes the CHRI to conduct any appropriate health assessment including, but not limited to, drug or alcohol screens on a practitioner before granting of privileges and at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical department or the director of medical affairs of the CHRI or their authorized designees.
- (2) The purpose of the health assessment shall be to ensure that the applicant or appointee to the CHRI medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the applicant or appointee would or is permitted to exercise by reason of medical staff appointment. If, at the time of the initial request for a health assessment, and at any time an appointee refuses to participate as needed in a health assessment, including, but not limited to, a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or the Wexner medical center board, the applicant or appointee will provide documentation of their physical/mental status with sufficient adequacy to demonstrate that any patient treated by the applicant or appointee will receive efficient and quality care at a professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as an appointee to the medical staff.
- (3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the applicant signs the application and the information is verified. A completed application must contain:
- (a) Peer recommendations from at least three individuals with first hand knowledge about the applicant's clinical and professional skills within the last year;

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- (b) Evidence of required immunizations;
 - (c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges;
 - (d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.
 - (e) Verification by primary source documentation of:
 - (i) Current and previous state licensure, and
 - (ii) Faculty appointment, when applicable.
 - (iii) DEA registrations, when required for the exercise of requested clinical privileges;
 - (iv) Graduation from an accredited professional school, when applicable;
 - (v) Successful completion or record of post professional graduate medical education;
 - (vi) Board certification or, active candidacy for board certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
 - (f) Information from the national practitioner data bank and other JCAHO approved sources;
 - (g) Verification that the applicant has not been excluded from any federally funded health care program; and
 - (h) Complete disclosure by the applicant of all past and current claims, suits, verdicts, and settlements, if any.
 - (i) Completion of a criminal background investigation that meets the requirements of the Wexner medical center.
 - (j) Completion of drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner medical center approved testing protocols.
 - (k) Verification of completion of specific competencies required for clinical privileges, as approved by the Medical Staff Administrative Committee and maintained in the provider's credentials files. All other required annual online learnings must be completed within sixty days of employment.
 - (l) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.
 - (m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.
- (4) The clinical department chief shall be responsible for investigating and verifying the character, qualifications and professional standing of the applicants by making inquiry of the

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primary source of such information and shall within thirty days of receipt of the completed application, submit a report of those findings along with a recommendation on medical staff membership and clinical privileges to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of applications for associates to the medical staff.

- (5) The department chairperson and/or division director shall receive all initial signed and verified applications from the appropriate clinical department chief and shall make a recommendation to the medical director of credentialing on each application. The medical director of credentialing shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information. The medical director of credentialing shall forward all completed applications to the credentials committee.
- (6) The applicants shall have the burden of producing information for an adequate evaluation of his/her qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn, action which is not subject to hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
- (7) If the clinical department chief does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the medical director of credentialing for presentation to the credentials committee on the same basis as other applicants.
- (8) Completed applications shall be acted upon as follows:
 - (a) By the credentials committee within thirty days after receipt of a completed application from the medical director of credentialing;
 - (b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report of the recommendation of the credentials committee;
 - (c) By the quality and professional affairs committee of the Wexner medical center board;
 - (d) By the Wexner medical center board within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee; and
 - (e) By the Wexner medical center board, or a subcommittee of the Wexner medical center board if eligible for expedited credentialing, within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.
- (9) These time periods are deemed guidelines only and do not periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights create any right to have an application processed within these precise specified in rule 3335-111-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.

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- (10) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the clinical department chief's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications, and ethical standing of the applicant and shall determine, through information contained in the personal references and from other sources available, whether the applicant established and met all of the necessary qualifications for the category of the medical staff and clinical privileges requested.
 - (11) The credentials committee shall, within thirty days from receipt of a completed application, make a recommendation to the medical director of credentialing that the application be accepted, rejected or modified. The medical director of credentialing shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the medical director of credentialing may recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session.
 - (12) The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the respective department chairperson and/or division director.
 - (13) At any time, the medical staff administrative committee first recommends non-appointment of an initial applicant for any category of the medical staff or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the medical director of credentialing to notify the applicant by certified return receipt mail that applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-111-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-111-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-111-06 of the Administrative Code. If an applicant fails to properly request a hearing, the medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.
 - (14) The director of medical affairs, who may make a separate recommendation to the Wexner medical center board, shall directly communicate the final recommendation of the medical staff administrative committee to the Wexner medical center board. When the Wexner medical center board has acted, the director of medical affairs will transmit the final decision to the clinical department chief, the applicant, the respective department chairperson and/or division director, and the Ohio state university board of trustees.
- (F) Procedure for reappointment.
- (1) Reappointment for all categories of the medical staff shall be for a period not to exceed thirty-six months. An appointment or grant of privileges for a period of less than thirty-six months shall not be deemed an adverse action. At least ninety days prior to the end of the medical staff member's or licensed allied health professional's appointment period, the clinical department chief shall provide each individual with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee.

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- (2) The reappointment application shall include all information necessary to update and evaluate the qualification of the applicant. The clinical department chief shall review the information available on each applicant for reappointment and shall make recommendations regarding reappointment to the medical staff and for granting of privileges for the ensuing appointment period. The clinical department chief's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the appropriate department chairperson and/or division director at least forty-five days prior to the end of the individual's appointment. The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Only completed applications for reappointment shall be considered by the credentials committee.
- (3) An application for reappointment is complete when all the information requested on the reappointment application is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application must contain:
 - (a) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges;
 - (b) Verification by primary source documentation of state licensure;
 - (c) DEA registration when required for clinical privileges as requested;
 - (d) Successful completion or record of any additional post graduate medical or professional education not submitted since initial or last appointment;
 - (e) Board certification, recertification, or continued active candidacy for certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
 - (f) Information from the national practitioner data bank;
 - (g) Verification that the applicant has not been excluded from any federally funded health care program;
 - (h) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines;
 - (i) Specific requests for any changes in medical staff category;
 - (j) A summary of the member's clinical activity during the previous appointment period;
 - (k) Verification of completion of any annual education requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office;
 - (l) Complete disclosure by individuals of claims, suits, verdicts and settlements, if any since last appointment; and
 - (m) Continuing medical education and applicable continuing professional education activities: documentation of category one CME that, at least in part, relates to the individual medical staff member's specialty or subspecialty area and is consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.

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- (n) Attending physicians only: submit information summarizing clinical research activities with each application.
 - (o) Attestation of current OARRS account for all applicants who have a DEA registration.
- (4) The applicant for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The clinical department chief shall review and evaluate the reappointment application and the supporting documentation. The clinical department chief shall evaluate all matters relevant to recommendation, including: the applicant's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs, if applicable; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the CHRI hospitals personnel and the use of the CHRI hospital's facilities for patients; relations with other physicians other health professionals or other staff; maintenance of a professional attitude toward patients; and the responsibility to the CHRI and the public.
- (5) The clinical department chief shall submit a report of those findings along with a recommendation on reappointment to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of application for associates to the medical staff. The department chairperson and/or division director shall review the reappointment application and forward to the medical director of credentialing with a recommendation for reappointment. The medical director of credentialing shall forward the reappointment forms and the recommendations of the clinical department chief and department chairperson and/or division director to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority, as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for continuing clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that all medical staff members deliver the same level of quality of care with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.
- (6) The credentials committee shall forward its recommendations to the medical director of credentialing at least thirty days prior to the end of the period of appointment for the individual. The medical director of credentialing shall transmit the completed reappointment application and recommendation of the credentials committee to the medical staff administrative committee.
- (7) Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership and all clinical privileges at the end of the medical staff member's current appointment period, action which shall not be subject to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically terminated shall be processed as a new appointment.
- (8) Failure of the clinical department chief to act in a timely manner on an application for reappointment shall be the same as provided in paragraph (E)(7) of this rule.
- (9) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for appointment to the medical staff and shall accept, reject, or modify the request for reappointment in the same

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manner and with the same authority as an original application. The recommendation of the medical staff administrative committee regarding reappointment shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the department chairperson and/or division director.

- (10) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension, or revocation of clinical privileges, the medical staff administrative committee shall instruct the medical director of credentialing to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (C) of rule 3335-111-06 of the Administrative Code apply. The notice by the medical director of credentialing shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.
- (11) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-111-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter. If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

(G) Resumption of clinical activities following a leave of absence:

- (1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the director of medical affairs. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the director of medical affairs provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the director of medical affairs and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the director of medical affairs that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.
- (2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board. The credentials committee, the director of medical affairs, the medical director of credentialing, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's

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or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

- (3) All members or credentialed providers of the medical staff who take a leave of absence for medical or non-medical reasons must be in good standing on the medical staff upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedure for appointment and reappointment, including deadlines for submission of application as set forth in this rule will apply irrespective of the nature of the leave. Absence extending beyond his or her current term of failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 2/6/2004, 11/4/2005, 8/6/2007, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 6/6/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 8/15/2023)

3335-111-05 Peer review and corrective action

(A) Informal peer review.

- (1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the CHRI.
- (2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.
- (3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.
- (4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.
- (5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the director of medical affairs. The clinical department chief and the director of medical affairs shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:
 - (a) The matter warrants no further action;
 - (b) Informal resolution under this paragraph is appropriate. The clinical department chief and the director of medical affairs shall determine whether to include documentation of the

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informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

- (c) Formal peer review under paragraph (B) of this rule is warranted. In cases where the clinical department chief and director of medical affairs cannot agree, the matter shall be submitted and determined as set forth in paragraph (B) of this rule.

(B) Formal peer review.

- (1) Formal peer review may be requested in more serious situations or where informal review has not resolved an issue or whenever the activities or professional conduct of a member of the medical staff of the CHRI:
 - (a) Violates the standards or aims of the medical staff or standards of professional conduct;
 - (b) Is considered to be disruptive to the operation of the CHRI;
 - (c) Violates the bylaws, rules and regulations of the medical staff, the Wexner medical center board, or the board of trustees of the Ohio state university;
 - (d) Violates state or federal law; or
 - (e) Is detrimental to patient safety or to the delivery of patient care within the CHRI.
- (2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director, the director of medical affairs, any member of the medical staff, the chief executive officer of the CHRI, the dean of the college of medicine, any member of the Wexner medical center board, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the director of medical affairs, and shall be supported by reference to the specific activities or conduct which constitute grounds for the requested action.
- (3) The director of medical affairs shall promptly notify the affected member of the medical staff, in a confidential manner, that a request for formal peer review has been made, and inform the member of the specific activities or conduct which constitute grounds for the requested action. The director of medical affairs shall verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the director of medical affairs decides that no further action is warranted, the director of medical affairs shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action would be taken.
- (4) Whenever the director of medical affairs determines that formal peer review is warranted and that a reduction, suspension or revocation of clinical privileges could result, the director of medical affairs shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings. The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the director of medical affairs under these rules for implementing corrective action and appellate procedure only if:
 - (a) The director of medical affairs is the medical staff member charged;

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- (b) The director of medical affairs is responsible for having the charges brought against another medical staff member; or
 - (c) There is an obvious conflict of interest.
- (5) The formal peer review committee shall investigate every request and shall report in writing its findings and recommendations for action to the appropriate clinical department chief and notice given to the division director. In making its recommendation the formal peer review committee may consider as appropriate, relevant literature and clinical practice guidelines, all the opinions and views expressed throughout the review process, and any information or explanations provided by the member under review. Prior to making its report, the medical staff member against whom the action has been requested shall be afforded an opportunity for an interview with the formal peer review committee. At such interview, the medical staff member shall be informed of the specific activities alleged to constitute grounds for formal peer review, and shall be afforded the opportunity to discuss, explain or refute the allegations against the medical staff member. The medical staff member may furnish written or oral information to the formal peer review committee at this time. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action is expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.
- (6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the executive vice president for health sciences or designee.
- (7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the executive vice president for health sciences or designee, shall approve or modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical affairs or executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; division director; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of

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medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

- (8) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.
- (9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

(C) Composition of the formal peer review committee.

- (1) When the determination that formal peer review is warranted is made, the clinical department chief shall select three members of the medical staff to serve on a formal peer review committee.
- (2) Whenever the questions raised concern the clinical competence of the member under review, the clinical department chief shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.
- (3) An external review consultant may serve as a member of the formal peer review whenever:
 - (a) A determination is made by the clinical department chief and the director of medical affairs that the clinical expertise needed to conduct the review is not available on the medical staff;
 - (b) The objectivity of the review may be compromised due to economic considerations; or
 - (c) Whenever the director of medical affairs determines that an external review is otherwise advisable.

If an external reviewer is recommended, the clinical department chief shall make a written recommendation to the director of medical affairs for selection of an external reviewer. The director of medical affairs shall make the final selection of an external reviewer.

(D) Summary suspension.

- (1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of clinical privileges immediately suspended or appointment terminated by the chief executive officer or department chairperson and/or division director, whenever such action must be taken when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the chief executive officer will subsequently notify the medical staff member in writing of the suspension. Such notice shall be by certified return receipt mail to the affected medical staff member's last known address as determined by university records.
- (2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to appeal the suspension pursuant to rule 3335-111-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief executive officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the affected member's right to

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any review by the medical staff administrative committee of which the member might otherwise been entitled. If a timely, written request for a hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

- (3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate department chairperson and/or division director, shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the hospital at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect, the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination.

- (1) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief executive officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff.
- (2) Action by the state boards of licensure revoking or suspending a medical staff member's licensure or placing the member on probation shall automatically impose the same restrictions to that member's CHRI medical staff privileges.
- (3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-111-04 and automatically relinquish his or her appointment and privileges.
- (4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall immediately and automatically terminate, unless resignation in lieu of automatic termination is permitted pursuant to rule 3335-43-04(A)(4).
- (5) If a medical staff member pleads guilty to or is found guilty of a felony which involves violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's appointment and privileges shall be immediately and automatically terminated.
- (6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.
- (7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.
- (8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-111-06 of the Administrative Code as a result of an automatic suspension or termination. As soon

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as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.

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3335-111-06 Hearing and appellate review procedure.

- (A) Right to hearing before the medical staff administrative committee and to appellate review.
 - (1) When a member of the medical staff has exhausted remedies under paragraph (F) of rule 3335-111-04 of the Administrative Code on reappointments; or under rule 3335-111-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-111-05 of the Administrative Code, the staff member shall be entitled to an adjudicatory hearing.
 - (2) A medical staff member shall not be entitled to a hearing under the following circumstances:
 - (a) Denial of the Wexner medical center board to grant a waiver of board certification for a medical staff member.
 - (b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.
 - (c) Voluntary withdrawal of a medical staff application.
 - (d) Failure to submit a reappointment application.
 - (e) A leave of absences extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.
 - (f) Actions or recommendations resulting from an informal peer review.
 - (3) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.
- (B) Request for hearing.
 - (1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief executive officer within thirty days of notifications by the chief executive officer of the intended action. The chief executive officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.
 - (2) The failure of a medical staff member to request a hearing to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the member's right to any review by the medical staff administrative committee to which the member might otherwise been entitled. The chief executive officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Wexner medical center board as provided for in paragraph (E) of this rule. The chief executive officer shall promptly inform the affected medical staff member

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that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

(C) Notice of hearing.

- (1) After receipt of a timely request for hearing by the chief executive officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief executive officer, and shall at the next scheduled meeting take the following action:
 - (a) Instruct the director of medical affairs and chief of staff to jointly appoint within seven days a hearing committee, consisting of three to five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the peer review of the matter under consideration.
 - (b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty nor more than sixty days from the date of the receipt of the request for a hearing by the chief executive officer. However, an initial hearing or meeting for a medical staff member who is under summary suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.
- (2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that the medical staff member may waive this notice in writing. Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

- (1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination. The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than two members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken the action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

- (2) An accurate record of the hearing shall be kept. The record shall be done by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the affected member's expense.

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- (3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the right to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The hearing committee may, at its own discretion, proceed with the hearing without the medical staff member and impose a sanction.
- (4) Postponements of hearings beyond the time set forth in this chapter shall be made only with the approval of the medical staff administrative committee. Granting of such postponement shall be only for good cause shown.
- (5) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.
- (6) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his/her own behalf, the member may be called and examined as if under cross-examination.
- (7) The hearing committee shall request the person who has taken the action from which the affected medical staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any party's witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written.
- (8) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may limit its proceedings when sufficient material has been received. The parties may be required to provide evidence in oral or written form. Upon conclusion of the presentation of evidence the hearing shall be closed. The hearing committee may there upon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.
- (9) Within sixty days after its appointment, unless otherwise extended by the medical staff administrative committee, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation presented by the parties to the medical staff administrative committee. The affected member shall be notified of the recommendation of the hearing committee including a statement of

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the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.

- (10) Within fourteen days after the conclusion of the taking of all evidence and of all hearings, the medical staff administrative committee shall make a written report of its findings and its recommendation and shall forward the same together with the hearings record and all other documentation to the chairperson of the Wexner medical center board. Notice of that decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records by the director.
- (11) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee of the Wexner medical center board may accept, reject, or modify the decision of the medical staff administrative committee.
- (12) The recommendation of the quality and professional affairs committee of the Wexner medical center board shall be promptly considered by the Wexner medical center board at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee of the Wexner medical center board.
- (13) A copy of the Wexner medical center board decision shall be sent by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.

(E) Appeal process.

- (1) Within thirty days after receipt of a notice by an affected medical staff member of the action of the medical staff administrative committee the staff member may, by written notice to the chairperson of the Wexner medical center board, request an appeal. Such appeal shall only be held on the record before the medical staff administrative committee.
- (2) If an appeal is not requested within the thirty-day period, the affected medical staff member shall be deemed to have waived the right to an appeal, and to have accepted such adverse decision.
- (3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.
- (4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the medical staff administrative committee and all other material, favorable or unfavorable, that have been considered by that committee. The member shall then submit a written factual statement specifying those factual and procedural matters with which the member disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee of the Wexner medical center board no later than seven days following the date of the affected member's notice of appeal.

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- (5) New or additional matters not raised during the hearing procedure or in the medical staff administrative committee hearings shall only be introduced on appeal at the sole discretion of the quality and professional affairs committee of the Wexner medical center board.
- (6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.
- (7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the department chairperson and/or division director, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

(Board approval dates: 9/1/1993, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018, 8/15/2023)

3335-111-07 Categories of the medical staff.

The medical staff of the CHRI shall be divided into honorary, physician scholar, attending, associate attending, clinical attending, consulting medical staff and limited designations. All medical staff members with admitting privileges may admit patients in accordance with state law and criteria for standards of care established by the medical staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last ~~two~~three years and specific annual education but are otherwise subject to the provisions of these bylaws.

(A) Honorary staff.

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, executive vice president for health sciences, department chairperson and/or division director, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

(B) Physician scholar medical staff.

- (1) **Qualifications:** The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

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- (2) Prerogatives: Members of the physician scholar medical staff shall have access to the CHRI and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.
- (3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(C) Attending medical staff.

(1) Qualifications:

The attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who are licensed or certified in the state of Ohio, whose practice is at least seventy-five percent oncology and with a proven career commitment to oncology as demonstrated by the majority of the following:

Training, current board certification (as specified in paragraph (A)(5) of rule 3335-111-04 of the Administrative Code), publications, grant funding, other funding and experience (as deemed appropriate by the chief executive officer and the department chairperson and/or division director); and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

Attending staff members may:

- (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the CHRI. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.
- (d) Hold office in the medical staff organization, clinical departments and committees of which they are a member, unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.

(3) Responsibilities:

An attending staff member shall:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

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- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRl for whom he or she is providing care, or arrange a suitable alternative for such care and supervision.
 - (c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such staff functions as may be required from time to time.
 - (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.
 - (e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services that the limited staff member is competent to perform under supervision.
 - (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.
 - (g) Take call as assigned by the clinical department chief.
- (D) Associate attending staff.
- (1) Qualifications:
The associate attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who do not qualify for attending staff appointment.
 - (2) Prerogatives:
The associate attending staff may:
 - (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the institution. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the associate attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
 - (b) Be free to exercise such clinical privileges as are granted pursuant to the bylaws.
 - (c) Vote on all matters presented at general and special meetings of the medical staff and at committees of which he or she is a member unless otherwise prohibited by these bylaws or by resolution approved by the medical staff administrative committee.
 - (d) The associate attending staff member may not vote on amendments to the bylaws.

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(3) Responsibilities:

Associate attending staff members shall:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Retain responsibility within the member's care area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.
- (c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.
- (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.

(E) Clinical attending staff.

(1) Qualifications:

The clinical attending staff shall consist of those clinical faculty members of the colleges of medicine and dentistry who have training, expertise, and experience in oncology, as determined by the chief executive officer in consultation with the department chairperson and/or division director and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

The clinical attending staff may:

- (a) Admit patients which complement the research and clinical teaching program. At times when hospital beds or other resources are in short supply, patient admissions of clinical staff shall be subordinate to those of attending or associate attending staff.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Attend meetings as non-voting members of the medical staff and any medical staff or hospital education programs. The clinical attending staff may not hold elected office in the medical staff organization.

(3) Responsibilities:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.

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- (c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.
- (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.
- (e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.

(F) Consulting medical staff.

(1) Qualifications.

The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

- (a) Satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.
- (b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services to James patients only at the request of attending or associate attending members of the medical staff.
- (c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the hospitals of the Ohio state university. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the James cancer hospital. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

- (a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or associate attending medical staff member.
- (b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals and James cancer hospital incidental to the clinical privileges granted pursuant to these bylaws.
- (c) Not admit patients to the Ohio state university hospitals or James cancer hospital.

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- (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.
 - (e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "consulting medical staff member policy."
 - (f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.
 - (g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as clinical department chief.
 - (h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.
- (3) Responsibilities.
- Each member of the consulting medical staff shall:
- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
 - (b) Be exempt from all medical staff dues.

(G) Contracted.

- (1) Qualifications: contracted medical staff shall consist of those members who meet the requirements for medical staff membership and are providing services to CHRI patients exclusively through a contract with the CHRI. Contracted medical staff members shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff and shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph.
- Contracted medical staff shall not be required to obtain appointment to the faculty of the Ohio state university. Contracted medical staff shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office or required to pay medical staff dues.
- (2) Prerogatives.
- Contracted medical staff may:
- (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
- (3) Any contracted medical staff member whose membership has been terminated due to loss of contract and/or clinical privileges shall not be entitled to request a hearing and appeal in accordance with rule 3335-111-06 of the Administrative Code.

(G)(H) Limited staff.

Limited staff are not considered members of the medical staff, do not have delineated clinical privileges, and do not have the right to vote in general medical staff elections. Except where expressly stated, limited staff are bound by the terms of these bylaws, rules and regulations of the medical staff and the limited staff agreement.

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(1) Qualifications:

The limited staff shall consist of doctors of medicine, osteopathic physicians, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a postdoctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws. The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state medical board, or the limited staff member's respective licensing board.

Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities:

The limited staff shall:

- (a) Be responsible to respond to all questions and complete all forms as may be required by the credentials committee.
- (b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.
- (c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending, associate attending or clinical attending medical staff. The limited staff member shall follow all rules and regulations of the service to which he or she is assigned, as well as the general rules of the CHRI pertaining to limited staff.
- (d) Serve as full members of the various medical staff committees in accordance with established committee composition as described in these bylaws and/or rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization, but may vote on committees to which the limited staff member is assigned.
- (e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or subspecialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical department chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.
- (f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training

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program will be conducted and limited in accordance with written guidelines established by the respective academic department or training program and approved by the program director and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-111-05 and 3335-111-06 of the Administrative Code.

(3) Failure to meet reasonable expectations:

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

(4) Temporary appointments:

- (a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. The appointment shall not exceed sixty days.
- (b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending or clinical attending medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending, associate attending or clinical attending medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending, associate attending or clinical attending medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending, associate attending or clinical attending medical staff member or the director of the training program.

- (a) Limited staff members may write admission, discharge or other orders for the care of patients under the supervision of the attending, associate attending or clinical attending medical staff member.
- (b) All records of limited staff member cases must document involvement of the attending, associate attending or clinical attending medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

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~~(H)(1)~~ Associates to the medical staff.

(1) Qualifications:

Licensed health care professionals are those professionals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care in a hospital setting, but who are not acting as licensed independent practitioners.

(2) Due process:

Licensed health care professionals are subject to corrective action for violation of these rules, their certificate of authority, standard care agreement, utilization plan or the provisions of their licensure, including professional ethics. Corrective action may be requested by any member of the medical staff, the clinical department chief, the chairperson of an academic

department, the section chief, the medical director of credentialing or the director of medical affairs. All requests shall be in writing and be submitted to the director of medical affairs.

The director of medical affairs shall appoint a three-person committee to review the situation and recommend appropriate corrective action, including termination or suspension of clinical privileges. The committee shall consist of at least one licensed health care professional licensed in the same field as the individual being reviewed, if available, and one medical staff member. The committee shall make a written recommendation to the director of medical affairs, who may accept, reject or modify the recommendation. The decision of the director of medical affairs shall be final.

~~(H)(2)~~ Temporary medical staff appointment.

- (1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer or director of medical affairs may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.
- (2) Proctoring. Temporary privileges may be extended to visiting physician or visiting medical faculty for special clinical or educational activities as permitted by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting medical faculty or visiting physician may apply for temporary privileges pursuant to the medical staff proctoring policy.

~~(H)(K)~~ Clinical privileges.

(1) Delineation of clinical privileges:

- (a) Every person practicing at the CHRI by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed allied health professional by the Wexner medical center board after recommendation from the medical staff administrative committee.
- (b) Each clinical department and CHRI department and/or division shall develop specific clinical criteria and standards for the evaluation of privileges with emphasis on invasive or therapeutic procedures or treatment which represent significant risk to

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the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

- (c) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such

request must include documentation of relevant training or experience supportive of the request.

- (d) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the medical director of credentialing. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible, the review should be of primary source information. The applicant shall have the burden of establishing qualifications and competence in the clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.
- (e) The applicant's request for clinical privileges and the recommendation of the clinical department chief shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-111-04 of the Administrative Code.
- (f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioner's professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.
- (g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.
- (h) Medical staff members authorize the CHRI and clinics to share amongst themselves credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the CHRI.
- (i) Medical staff members authorize the CHRI to release, in good faith and without malice, information to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical

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privileges, participation or other credentialing or quality matters.

- (2) Temporary and special privileges:
 - (a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed allied health professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department. All temporary privileges are granted by the chief executive officer or authorized designee. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to

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granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient care need and shall not be granted for a period not to exceed one hundred twenty days.

- (b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental boards.
 - (c) Temporary privileges granted for locum tenens may be exercised for a maximum of one hundred twenty days, consecutive or not, any time during the thirty-six month period following the date they are granted.
 - (d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.
 - (e) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.
 - (f) Special privileges -- upon receipt of a written request for specific temporary clinical privileges and the approval of the clinical department chief, the chairperson of the academic department and the director of medical affairs, an appropriately licensed or certified practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special clinical privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in rule 3335-111-04 of the Administrative Code.
 - (g) The temporary and special privileges must also be in conformity with accrediting bodies' standards and the rules and regulations of professional boards of Ohio.
- (3) Expedited privileges:

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, eligible applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgment against the applicant, or a challenge by a state licensing board.

(4) Podiatric privileges:

- (a) Practitioners of podiatry may admit patients to the CHRI if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.
- (b) A member of the medical staff who is a doctor of medicine or osteopathy.
 - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and

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- (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.
 - (c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.
 - (d) The podiatrist shall be responsible to the chief of the department of orthopaedics.
- (5) Psychology privileges:
 - (a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise unless otherwise authorized by law.
 - (b) Psychologists may not admit patients to the CHRI, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the CHRI. In ambulatory settings, psychologists shall diagnose and treat their patient's psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.
 - (c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.
- (6) Dental privileges:
 - (a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the CHRI if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.
 - (b) A member of the medical staff who is a doctor of medicine or osteopathy:
 - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and
 - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnoses or therapeutic interventions defined by the medical staff.
 - (c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

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(7) Oral and maxillofacial surgical privileges:

All patients admitted to the CHRI for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Licensed allied health professionals:

- (a) Clinical privileges may be exercised by licensed allied health professionals who are duly licensed in the state of Ohio and who are either:
 - (i) Members of the faculty of the Ohio state university, or
 - (ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or
 - (iii) Employees of members of the medical staff.
- (b) A licensed allied health professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed allied health professionals may perform all or part of the medical history and physical examination of the patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.
- (c) Licensed allied health professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-111-04 of the Administrative Code.
- (d) Licensed allied health professionals are not members of the medical staff, but may write admitting orders for patients of the CHRI when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed allied health professionals are not members of the medical staff and shall not be eligible to hold office, to vote on medical staff affairs, or to serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.
- (e) Each licensed allied health professional shall be individually assigned to a clinical department and shall be supervised by or collaborate with one or more members of the medical staff as required by Ohio law. The licensed health care professional's clinical privileges are contingent upon the collaborating/supervising medical staff member's privileges. In the event that the collaborating/supervising medical staff member loses privileges or resigns, the licensed allied health care professionals whom he or she has supervised shall be placed on administrative hold until another collaborating/ supervising medical staff member is assigned. The new collaborating/supervising medical staff member shall be assigned in less than thirty days.

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- (f) Licensed allied health professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.
- (g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed allied health professional:
 - (i) Current license, certification, or other legal credential required by Ohio law;
 - (ii) Certificate of authority, standard care arrangement/agreement, or utilization plan;
 - (iii) Education, training, professional background and experience, and professional competence;
 - (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed allied health professional subcommittee and the quality management department of the Ohio state university medical center;
 - (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law;
 - (vi) Evidence of required immunization;
 - (vii) Evidence of good personal and professional reputation as established by peer recommendations;
 - (viii) Satisfactory physical and mental health to perform requested clinical privileges; and
 - (ix) Ability to work with members of the medical staff and the CHRI employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the CHRI that any patient cared for by the licensed allied health professional seeking clinical privileges shall be given quality care, and that the efficient operation of the CHRI will not be disrupted by the applicant's care of patients in the CHRI.
- (i) By applying for clinical privileges as a licensed allied health professional, the applicant agrees to the following terms and conditions:
 - (i) The applicant has read the bylaws and rules and regulations of the medical staff of the CHRI and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable CHRI policies that the CHRI may from time to time put into effect;
 - (ii) The applicant releases from liability all individuals and organizations who provide information to the CHRI regarding the applicant and all members of the medical staff, the CHRI staff and the Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant;

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- (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the CHRI;
 - (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed allied health professional is a member of the medical staff; and
 - (v) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.
- (j) Licensed allied health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the medical director of quality or the chief quality officer. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer, unless delegated to the medical director of quality, shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed allied health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, unless delegated to the medical director of quality, who may accept, reject, or modify the recommendation. The chief quality officer, unless delegated to the medical director of quality shall forward his or her recommendation to the director of medical affairs for final determination.
- (k) Appeal process.
 - (i) A licensed allied health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.
 - (ii) If an appeal is not so requested within the thirty-day period, the licensed allied health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the director of medical affairs.
 - (iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed allied health care professional under review. The licensed allied health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.
 - (iv) The affected licensed allied health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed allied health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review

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committee no later than seven days following the date of the licensed allied health care professional's notice of appeal.

- (v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
 - (vi) Within thirty days following submission of the written statement by the licensed allied health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.
 - (vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed allied health care professional as determined by university records. The chief quality officer shall also notify in writing the senior vice president for health sciences, the dean of the college of medicine, the chief executive officer of the CHRl and the vice president for health services and the chief of the applicable clinical department or departments. The chief quality officer, unless delegated to the medical director of quality, shall take immediate steps to implement the final decision.
- (9) Emergency privileges:
- In the case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the CHRl necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition that would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- (10) Disaster privileges:
- Disaster privileges may be granted in order to provide voluntary services during a local, state or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the director of medical affairs or the medical director of credentialing to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the director of medical affairs temporary privileges are granted thereafter.
- (11) Telemedicine privileges.
- Practitioners who provide contracted patient care, treatment, and services via telemedicine shall be credentialed and privileged to provide such services. A grant of telemedicine privileges shall include appointment to the contracted medical staff category as described in paragraph (G) of this rule.

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Practitioners providing contracted telemedicine services shall be credentialed and privileged through one of the following mechanisms:

- (a) The practitioner shall be credentialed and privileged in accordance with rule 3335-111-04.
- (b) The practitioner shall be credentialed and privileged by proxy using the credentialing and privileging decision from the distant site if all of the following requirements are met:
 - (i) The distant site is also accredited by the Joint Commission.
 - (ii) The distant site is a Medicare-participating hospital or a facility that qualifies as a distant-site telemedicine entity under federal regulations.
 - (iii) The Ohio state university hospitals have entered into a written agreement with the distant site.
 - (iv) If the distant site is a Medicare-participating hospital, the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the Centers for Medicare and Medicaid Services conditions of participation applicable to medical staff credentialing and privileging.
 - (v) If the distant site is a distant-site telemedicine entity as defined by federal regulations, the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Ohio state university hospitals and furnishes the contracted services in a manner that allows the Ohio State university hospitals Hospital to comply with all applicable Centers for Medicare and Medicaid Services conditions of participation for contracted services and for medical staff credentialing and privileging.
 - (vi) The individual distant-site practitioner is privileged at the distant site for those services to be provided to patients of the Ohio state university hospitals via telemedicine and the distant site provides a current list of the practitioner's privileges at the distant site.
 - (vii) The individual distant-site practitioner holds an appropriate license, telemedicine certificate, or telemedicine waiver issued by the applicable Ohio licensing board for the practitioner's area of practice.
 - (viii) The Ohio state university hospitals maintain documentation of all internal reviews of the performance of each distant-site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant-site Practitioner's privileges. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to patients of the Ohio state university hospitals, and all complaints the Ohio state university hospitals receive about the distant-site practitioner.

(11) Telemedicine:

~~Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link.~~

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- (a) ~~A member of the medical staff who wishes to utilize electronic technologies (telemedicine) to render care must so indicate on the application for clinical privileges form.~~
- (b) ~~A member of the medical staff may request to exercise via telemedicine the same clinical privileges he or she has already been granted. The credentials committee, the chief of the clinical service, medical director of credentialing, the director of medical affairs or the medical staff administrative committee, and the Wexner medical center board shall have the prerogative of requiring documentation or making a determination of the appropriateness of the exercise of a particular specialty/subspecialty via telemedicine.~~

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 8/6/2006, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015, 4/6/2018, 5/18/2021, 2/8/2022, 8/15/2023)

3335-111-08 Organization of the CHRI medical staff.

- (A) The chief executive officer.
- (1) Method of appointment:
- The chief executive officer shall be appointed by the board of trustees of the Ohio state university upon recommendation of the president, executive vice president for health sciences, and the vice president for health services following consultation with the medical center board in accordance with university bylaws, rules and regulations. The chief executive officer shall be a member of the attending medical staff of the CHRI.
- (2) Responsibilities:
- The chief executive officer shall be responsible for the conduct of teaching, research, and CHRI service activities of the facility, including continuing compliance with all appropriate quality assurance standards, ethical codes, or other monitoring or regulatory requirements. The chief executive officer shall be a member of all committees of the CHRI.
- (B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).
- (1) Method of appointment:
- The director of medical affairs shall be appointed by the executive vice president for health sciences upon recommendation by the chief executive officer of the James Cancer Hospital. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.
- (2) Responsibilities:
- The director of medical affairs shall report to the chief executive officer and the Wexner medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing. In addition, the director of medical affairs determines initial medical staff category appointments, reappointments and any changes in categories of the medical staff.

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- (C) The chief medical officer of the Ohio state university medical center.

The chief medical officer of the Ohio state university medical center is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state medical center board bylaws. The director of medical affairs will work collaboratively with the chief medical officer and medical directors of each hospital of the medical center for the: coordination and supervision of patient care and clinical activities; responsibility for the clinical organization of his or her respective hospital; and to establish priorities, jointly with the chief executive officer or executive director of his or her respective hospital, for capital medical equipment, clinical space, and the establishment of new clinical programs, or the revision of existing clinical programs.

- (D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer. The chief quality officer works collaboratively with clinical leadership of the medical center, including medical director of quality for the CHRI, director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

- (E) Medical director of credentialing.

The medical director of credentialing for the James cancer hospital oversees the process for the credentialing of practitioners applying for membership and/or clinical privileges at the James cancer hospital. The medical director of credentialing shall provide guidance on specific practitioner application or privileging concerns as raised pursuant to these bylaws and shall recommend practitioners for membership and/or privileges at the James cancer hospital and facilitate the process for approving such membership and granting of clinical privileges.

- (F) Medical director, James surgical services.

The medical director, James surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the medical director, James surgical services facilitates the timely sharing of OR resources (including personnel and equipment) across the medical center in order to maximize the efficiency of OR services. The medical director, James surgical services works with clinical service lines and clinical leadership to coordinate OR services in a manner that enhances the quality of care and safety of services for patients. The medical director, James surgical services reports to the director of medical affairs of the James.

- (G) Professional assignments.

Each member of the attending, associate attending, clinical, limited, physician scholar and honorary staff shall be assigned to a CHRI division and/or department by the chief executive officer upon the recommendation of the appropriate academic department chairperson and the credentials committee.

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Appointment to a specific department and/or division is based on the clinical specialty of the applicant for medical staff membership. Each department and/or division is headed by a department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the department and/or division. Specifically, the department chairperson or division director shall be responsible for the following: the development and implementation of policies and procedures that guide and support the provision of service; recommendations re: staffing needs and clinical privileges for all members appointed to the department and/or division; the orientation and continuing surveillance of the professional performance of all department and/or division members; recommendation for space and other resources needed.

(H) Clinical department chief.

- (1) Qualifications and responsibilities of the chief of the clinical department. The academic department chair shall ordinarily serve also as the chief of the clinical department. Each clinical department chief shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each clinical department chief must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the colleges of medicine or dentistry. Qualifications for chief of the clinical department generally shall include recognized clinical competence, sound judgment and well-developed administrative skills.
- (2) Procedure for appointment. Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective colleges of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer of the Ohio state university medical center.
- (3) Term of appointment of the chief of the clinical department. The term of the appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(2) of this rule.
- (4) Duties of the chief of the clinical department:

Each clinical department chief is responsible for the following:

- (a) Clinically related activities of the department;
- (b) Administratively related activities of the department, unless otherwise provided by the hospital;
- (c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;
- (d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;

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- (f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;
- (g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;
- (h) The coordination and integration of interdepartmental and intradepartmental services;
- (i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;
- (j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including call coverage for continuous high quality and safe care;
- (k) The determination of the qualifications and competence of department or service personnel who are not licensed practitioners and who provide patient care, treatment, and services;
- (l) The continuous assessment and improvement of the quality of care, treatment, and services;
- (m) The maintenance of quality control programs, as appropriate;
- (n) The orientation and continuing education of all persons in the department or service;
- (o) Recommending space and other resources needed by the department or service; and
- (p) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of the departmental meetings, including a record of attendance, shall be kept in the clinical department.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/01/2013, 6/6/2014, 11/6/2015, 4/6/2018, 8/15/2023)

3335-111-09 Elected officers of the medical staff of the CHRI.

- (A) Chief of staff.

The chief of staff shall:

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- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
- (2) Be a vice chairperson of the medical staff administrative committee and serve as liaison between university administration, CHRI administration, and the medical staff in all matters of mutual concern within the CHRI.
- (3) Call, preside, and be responsible for the agenda of all general staff meetings.
- (4) Make medical staff committee appointments in accordance with paragraph (A) of rule 3335-111-10 of the Administrative Code.
- (5) Be a spokesperson for the medical staff in its external professional and public relations.
- (6) Serve as chairperson of the nominating committee of the medical staff.

(B) Chief of staff-elect.

The chief of staff-elect shall:

- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
- (2) Serve as the chairperson of the bylaws committee of the CHRI.
- (3) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.
- (4) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.
- (5) Assist the Chief of Staff with duties outlined above in section (A) 1-6.

(C) Delegates at-large.

Up to two additional at-large member(s) may be appointed to the medical staff administrative committee at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal every two years.

(D) Qualifications of officers.

- (1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- (2) The chief executive officer and director of medical affairs, chiefs of the clinical departments, and division directors are not eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their CHRI administrative role during the period of their term of office.

(E) Election of officers.

- (1) All officers (other than at-large officers) will be elected by a majority of those voting by electronic ballot after the April meeting of the medical staff. If one candidate does not achieve a majority vote, there will be an election on a second ballot between the two receiving the greatest number of votes.

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- (2) The nominating committee will be composed of five members. The chief of staff and the chief of staff-elect will serve on the committee and the chief of staff will be its chairperson. The chief of staff will appoint the three other members of the committee.
- (3) Nominations for officers will be accepted from the floor at the March meeting.
- (4) The committee's nominees will be submitted by electronic or written ballot to all voting members of the medical staff no later than May.
- (5) Candidates for the office of chief of staff-elect will be listed and each attending staff member may vote for one.
- (6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the CHRI, its goal and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.

(F) Term of office.

- (1) The chief of staff and chief of staff-elect will each serve two years in office beginning on the first of July. The chief of staff-elect will be elected in the odd years. The chief of staff may not be elected chief of staff-elect within one year of the end of the chief of staff's term in office.
- (2) The at-large representatives shall serve two years, beginning on the first of July. The delegate at large may succeed themselves for three successive terms (six years, total), if so elected. They may not serve again without a period of two years out of office as a delegate at large. The delegate at large may be elected chief of staff-elect at any time if they are members of the attending staff.

(G) Vacancies in office.

- (1) Vacancies in the office of chief of staff during the chief's term will be automatically succeeded and performed by the chief of staff-elect. When the unexpired term is one year or less, the new chief of staff will continue in office until the completion of the expected term in that office. When the unexpired term is more than one year, the new chief of staff will serve out the remaining term only.
- (2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of establishing the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The nominating committee will make nominations and a special meeting of the voting members of the medical staff will be called to add nominations and elect the replacement. The new chief of staff-elect will become chief of staff at the end of the term of the incumbent.
- (3) Vacancies in the at-large representatives' positions will be filled by appointment by the chief executive officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 2/11/2011, 4/8/2011, 6/6/2014, 9/2/2016, 4/6/2018, 5/18/2021, 8/15/2023, 8/20/2024)

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Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

Updated August 20, 2024

3335-111-10 Administration of the medical staff of the CHRI.

Medical staff committees.

- (A) **Appointments:** Appointments to all medical staff committees except the medical staff administrative committee (MSAC) and the nominating committee will be made jointly by the chief of staff, chief of staff-elect, and the director of medical affairs with medical staff administrative committee ratification. Unless otherwise provided by the bylaws, all appointments to medical staff committees are for two years and may be renewed. The chairperson shall control the committee agenda, attendance of staff and guests and conduct the proceedings. A simple majority of appointed voting members shall constitute a quorum. All committee members appointed or elected to serve on a medical staff committee are expected to participate fully in the activities of those committees. The chief of staff, director of medical affairs and the chief executive officer of the CHRI may serve on any medical staff committee as an ex-officio member without vote.
- (B) The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and monitoring the quality and utilization of patient care services provided by CHRI.
- (C) **Medical staff administrative committee:**
 - (1) **Composition:**
 - (a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, clinical department chief or division director of medical oncology, radiation oncology, anatomic pathology and molecular pathology; department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma pulmonary, critical care, sleep medicine, and urology; medical director of James emergency services; clinical department chiefs of anesthesia, dermatology, physical medicine and rehabilitation, plastic surgery, psychiatry, and radiology; CHRI medical director of quality, CHRI medical director of credentialing, CHRI chief executive officer, CHRI director of medical affairs, director of the division of palliative medicine, chairperson of the cancer subcommittee, CCC director for clinical research, CCC director for cancer control, and medical director of the James surgical services. Up to two additional at-large member(s) may be appointed to the MSAC at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis. If a division director is a member by leadership position, he or she will also fulfill the role of division director appointment. The director of medical affairs shall be the chairperson and the chief of staff shall be the vice-chairperson.
 - (b) Ex-officio non-voting membership includes: the CHRI executive director, the CHRI chief nursing officer, the CHRI executive director of patient services, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine and the executive vice president for health sciences.
 - (c) Any member of the committee who anticipates absence from a meeting of the committee may appoint a temporary substitute as a representative at the meeting. The temporary substitute will have all the rights of the absent member.

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- (d) All members of the committee shall attend, either in person, virtual, or by proxy, a minimum of two-thirds of all committee meetings.
 - (e) Any members may be removed from the medical staff administrative committee at the recommendation of the dean of the college of medicine, the director of medical affairs or the executive vice president for health sciences and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's composition as stated in this paragraph.
- (2) Duties:
- (a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by this chapter, and the bylaws or rules of the Ohio state university.
 - (b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to rule 3335-43-13 of the Administrative Code.
 - (c) To receive and act upon commission and committee reports. To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.
 - (d) To approve and implement policies of the medical staff.
 - (e) To recommend action to the chief executive officer on matters of medico-administrative nature.
 - (f) To fulfill the medical staff's accountability to the Wexner medical center board for medical care rendered to patients in the CHRI, and for professional conduct and activities of the medical staff, including recommendations concerning;
 - (i) Medical staff structure;
 - (ii) The mechanism to review credentials and to delineate clinical privileges;
 - (iii) The mechanism by which medical staff membership may be terminated or suspended;
 - (iv) Participation in the CHRI's performance improvement, quality and patient safety activities; and
 - (v) Corrective action and hearing procedures applicable to medical staff members and other licensed allied health professionals granted clinical privileges.
 - (g) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the CHRI.
 - (h) To review and act on medical staff appointments and reappointments.
 - (i) To report to the medical staff all actions affecting the medical staff.

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- (j) To inform the medical staff of all changes in committees, and the creation or elimination of such committees as circumstances shall require.
- (k) To create committees (for which membership is subsequently appointed pursuant to rule 3335-111-10 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.
- (l) To establish and maintain rules and regulations governing the medical staff.
- (m) To oversee functions related to performance improvement of professional services provided by individuals with clinical privileges.
- (n) To perform other functions as are appropriate.

(3) Executive session.

Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.

(4) Meetings:

The committee shall meet monthly and keep detailed minutes, which shall be distributed to each committee member before or at the next meeting of the committee.

(5) Voting:

At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein two-thirds of members present shall be required.

(D) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of the medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each hospital.

The chief medical officer of the medical center shall appoint the credentialing committee of the hospitals of the Ohio state university. The director of medical affairs and medical director of credentialing shall make recommendation to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, whom shall be appointed by the chief medical officer of the medical center.

(2) Duties:

- (a) To review all applications for medical staff and licensed allied health professional appointment and reappointment, as well as all requests for delineation, renewal, or

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amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;

- (b) To review triennially all applications for reappointment or renewal of clinical privileges;
 - (c) To review all requests for changes in medical staff membership;
 - (d) To assure, through the chairperson of the committee, that all records of peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;
 - (e) To make recommendations to the medical staff administrative committee through the medical director of credentialing regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division and/or department), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;
 - (f) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;
 - (g) The committee, after review and investigation, may make recommendations to the director of medical affairs, chief of staff, or the chief of a clinical department, regarding the restriction or limitation of any medical staff member's clinical privileges, noncompliance with the credentialing process, or any other matter related to its responsibilities;
 - (h) To review requests made for clinical privileges by other licensed allied health professionals as set forth in this chapter.
 - (i) To recommend eligibility criteria for the granting of medical staff membership and privileges.
 - (j) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.
 - (k) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.
 - (l) To perform such other functions as requested by the medical staff administrative committee, quality and professional affairs committee or Wexner medical center board.
- (3) Licensed health care professionals subcommittee:

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- (a) This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (A) of rule 3335-111-10 of the Administrative Code. This subcommittee shall be chaired by a director of nursing.
- (b) Duties:
 - (i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university;
 - (ii) To review and investigate the character, qualifications and professional competence of the applicant;
 - (iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal;
 - (iv) To verify the accuracy of the information contained in the application; and
 - (v) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.
 - (vi) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed allied health care professional specialty. These policies and procedures shall be ratified by the credentialing committee, and medical staff administrative committee and be approved by the Wexner medical center board.

(E) Medical staff bylaws committee:

- (1) Composition.

The committee shall be composed of at least four members of the attending staff pursuant to paragraph (A) of rule 3335-111-10 of the Administrative Code. The chairperson shall always be the chief of staff-elect.
- (2) Duties.

To review and recommend amendments to the medical staff administrative committee as necessary to maintain bylaws that reflect the structure and functions of the medical staff but not less than every two years. This committee will recommend changes to the medical staff administrative committee.

(F) Committee for practitioner health.

- (1) Composition.

The committee shall consist of medical staff members appointed in accordance with paragraph (A) of rule 3335-111-10 of the Administrative Code.
- (2) Duties:

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- (a) To consider issues of licensed practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, CHRI hospital staff, or any other individual.
- (b) To provide appropriate counsel, referral, and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.
- (c) To consult regularly with the chief of staff, medical director of credentialing and director of medical affairs of the CHRI.
- (d) To advise credentials and/or other appropriate medical staff committees on the credibility of a complaint, allegation or concern, including those affecting the quality and safety of patient care.
- (e) It will be the responsibility of the chairperson of the committee to assure that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest of confidence in accordance with the laws of the state of Ohio.
- (f) To educate CHRI hospital and the medical staff about illness and impairment recognition issues, including at risk criteria specific to licensed practitioners.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, radiology, radiation oncology, anesthesia, plastic surgery, urology, otolaryngology/head and neck, hematology, gynecologic oncology, thoracic surgery, orthopaedic oncology, neurological oncology, emergency medicine, palliative medicine and pathology, the cancer liaison physician and non-physician representatives from the cancer registry, administration, nursing, social services, and quality assurance. Other disciplines should be included as appropriate for the institution. The chairperson is appointed at the recommendation of the chief executive officer of the CHRI and the director of medical affairs, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis.

(2) Duties:

- (a) Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.
- (b) Promote a coordinated, multidisciplinary approach to patient management.
- (c) Ensure that educational and consultative cancer conferences cover all major site and related issues.
- (d) Ensure that an active supportive care system is in place for patients, families, and staff.
- (e) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.

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- (f) Promote clinical research.
- (g) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting.
- (h) Perform quality control of registry data.
- (i) Encourage data usage and regular reporting.
- (j) Ensure content of the annual report meets requirements.
- (k) Publishes the annual report by November first of the following year.
- (l) Upholds medical ethical standards.
- (m) Serve as cancer committee for commission on cancer program of the American college of surgeons.

(3) Meetings:

- (a) The subcommittee shall meet in collaboration with the medical staff administrative committee as a policy-advisory and administrative body with documentation of activities and specialties in attendance.
- (b) Any member anticipating an absence from the meeting should designate a representative to attend in their place.

(H) Ethics committee.

(1) Composition.

The committee is a joint committee and shall consist of members of the medical staff, nursing, hospital administration, and other persons representing both the CHRI and UH who, by reason of training, vocation, or interest, may make a contribution. Appointments will be made as provided by in this chapter. The chairperson shall be a physician who is a clinically active member of the medical staff of UH or the CHRI.

(2) Duties

- (a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.
- (b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the CHRI.
- (c) To provide a support mechanism for primary decision makers at the CHRI.
- (d) To provide educational resources on ethics to all health care providers at the CHRI.
- (e) To provide and enhance interaction between CHRI administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(I) Practitioner evaluation committee.

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(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the director of medical affairs an external review.

(2) Duties:

- (a) To meet regularly and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer, unless delegated to the medical director of quality and the chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and patient safety office.
- (b) To ensure that ongoing and systematic monitoring, evaluation and process improvement is performed in each clinical department.
- (c) To develop and utilize objective criteria in practitioner peer review activities.
- (d) To ensure that the medical staff peer review process is effective.
- (e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of the practitioner evaluation committee by any individual, clinical department, division, or committee.

(J) Committee for practitioner effectiveness.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

- (a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;
- (b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;
- (c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;
- (d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;
- (e) Forward all recommendations to the clinical department chief, director of medical affairs or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021, 8/15/2023, 8/20/2024)

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3335-111-11 History and physical.

- (A) History and physical examination.
- (1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:
 - (a) Admitted to the hospital
 - (b) Undergoing outpatient/ambulatory procedures requiring anesthesia or sedation
 - (b) Undergoing outpatient/ambulatory surgery
 - (d) In a hospital-based ambulatory clinic
 - (2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:
 - (a) Date of admission
 - (b) Chief complaint and/or indication for procedure
 - (c) History of present illness
 - (d) Past medical and surgical history
 - (e) Relevant past social and family history
 - (f) Medications and allergies
 - (g) Review of systems
 - (h) Physical examinations
 - (i) Test results
 - (j) Assessment or impression
 - (k) Plan of care
 - (3) For patients undergoing outpatient/ambulatory procedures requiring anesthesia or sedation or outpatients/ambulatory surgery, the history and physical examination shall include at a minimum:
 - (a) Indication for procedure/surgery
 - (b) Relevant medical or surgical history
 - (c) Medications and allergies or reference to current listing in the electronic medical record
 - (d) Focused review of systems, as appropriate
 - (e) Pre-procedure assessment and physical examination

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(f) Assessment/impression and treatment plan

(4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:

(a) Chief complaint

(b) History of present illness

(c) Medications and allergies

(d) Problem-focused physical examination

(e) Assessment or impression

(f) Plan of care

(B) Deadlines and sanctions

(1) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed healthcare professional, who is appropriately credentialed by the hospital, and be signed, dated and timed.

(2) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed healthcare professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

(3) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.

(4) Admitted patients or patients undergoing a procedure requiring anesthesia or sedation or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission, or the procedure/surgery. If completed before admission or the procedure, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission, or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, dated and timed. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.

(a) For patients undergoing an outpatient procedure requiring anesthesia or sedation or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

(b) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required

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to be countersigned.

- (5) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.
- (6) When the history and physical examination including the results of indicated laboratory studies and x-rays is not recorded in the medical record before the times stated for a procedure or surgery, the procedure or surgery cannot proceed until the history and physical is signed or countersigned, when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee.
- (7) Ambulatory patients must have a history and physical at the initial visit.
- (8) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:
 - (a) Within the past six months prior to the initial visit,
 - (b) At the initial visit, or
 - (c) Within thirty days following the initial visit.

(Board approval dates: 5/14/2010, 6/6/2014, 11/7/2014, 11/6/2015, 8/20/2024)

3335-111-12 Amendments and adoption.

(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt

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amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to: amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five percent (25%) of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via secure ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least fourteen days advance notice of the changes to be adopted:

- (1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.
- (2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment

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to any rules, regulation, or policy by submitting a petition signed by twenty-five per cent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

- (D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval dates: 9/1/1993, 3/3/1995, 12/3/1999, 9/6/2002, 2/6/2004, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 11/7/2014, 8/15/2023)

3335-111-13 Meetings and dues.

- (A) Meetings.

The medical staff of the CHRI shall conduct scheduled meetings semi-annually. Notice of the meetings will be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special or electronic meetings may be called at the option of the medical staff administrative committee.

- (B) Dues. The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued medical staff membership except honorary, clinical, and limited staff.

(Board approval date: 4/8/2011)

3335-111-14 Rules of construction.

- (A) "Shall" as used herein is to be construed as mandatory.
(B) These bylaws should be construed to be gender neutral.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 9/6/2002, 5/14/2010, 4/8/2011)

ATTACHMENT XL

Joint Bylaws Committee Meeting University Hospitals and The James

August 21, 2025

Summary of Proposed Amendments

The James Bylaws

- Proposed changes to 3335-43-04 (Membership) and 3335-111-07 (Categories of the medical staff) describing the required period of active clinical practice from “two” years to “three” to bring in-line with current recredentialing cycles.
- Proposed addition of Contracted medical staff category in 3335-111-07(G) to align with Contracted medical staff category in University Hospitals Bylaws and to align with current workflow of Corporate Credentialing.
- Proposed addition of granting telemedicine privileges by proxy as permitted by Centers for Medicare and Medicaid Services Conditions of Participation and by Joint Commission standards – added at 3335-111-07(K)(11).
- Removal of outdated telemedicine privilege language in same paragraph. Telemedicine privileges for health system employed providers are now addressed on delineation of privilege forms.

The James Rules and Regulations

- Proposed deletion of “as verified by the attending medical staff member’s signature” from Rule 10 (Medical records) at paragraph (A)(1)(a)(xii)(d) to remove this additional requirement that is not present in UH bylaws.



MEDICAL STAFF RULES AND REGULATIONS
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
as of August 15, 2023

01 Ethical pledge.

- (A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:
- (1) Refraining from fee splitting or other inducements relating to patient referral;
 - (2) Providing for continuity of patient care;
 - (3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;
 - (4) Seeking consultation whenever necessary; and
 - (5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 7/7/2006, 8/31/2012, 4/6/2016)

02 Admission procedures.

- (A) Except in an emergency, in the interest of assignment to the appropriate service, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician a member of the attending staff, limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the responsible medical staff member. The request for admission shall also include the following information:
- (1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.
 - (2) Any information which will warn responsible hospital personnel of any tendency of any patient to commit suicide or to injure others because of mental disturbance.
 - (3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.
- (B) It shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger. The attending physician is responsible to provide a comprehensive plan of care, including emergency care.

(Board approval dates: 9/18/2009, 4/6/2016)

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03 Attending assignment.

- (A) All patients entering the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI) who have not requested the services of a member of the medical staff to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to the CHRI. This shall also apply to the transfer of patients within the services of the CHRI.

- (B) Alternative attending medical staff member coverage.

Each division shall have a plan for medical coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or limited medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available, the director of medical affairs, section chiefs, department chair or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable.

- (C) In the case of a medical or psychiatric emergency involving a patient, visitor or CHRI staff member in an inpatient or outpatient setting, any individual who is a member of the medical staff or who has been delineated privileges is permitted to do everything possible to save the life or prevent serious harm regardless of the individual's staff status or clinical privileges.

(Board approval dates: 11/4/2005, 2/11/2011, 4/6/2016)

04 Consultations.

- (A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the medical staff member's area of training and experience, it is the responsibility of the medical staff member or his or her designee (with appropriate credentials) to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to 10:00 a.m., the consult shall occur on the same business day. If a consultation is ordered after 10:00 a.m., the consult shall occur within twenty-four hours. Each patient is continuously assessed and his or her plan for care is modified as necessary.

- (B) Responsibility to monitor consultations.

It is the duty of the medical staff, through its clinical section chief and the medical staff administrative committee, to assure that members of the staff comply in the matter of requesting consultations as needed.

- (C) Consultation contents.

A satisfactory consultation shall be rendered within one day of the request and shall include examination of the patient, examination of the medical record, and a written opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 4/8/2011, 4/6/2016)

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05 Order writing privileges.

(A) Definition of "patient orders".

- (1) A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule and shall be authenticated by the licensed medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word "written" and its grammatical derivatives, as used to describe a nonverbal order, refer to both written and electronically entered orders.
- (2) Electronic orders are equivalent and have the same authority as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(B) Responsible medical practitioner.

All patient care is the responsibility of the attending, associate attending, clinical attending, or community associate attending staff. Coverage may be provided by the limited staff or another licensed healthcare professional with appropriate clinical privileges under supervision. The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) with appropriate clinical privileges responsible for the hospitalization or outpatient care, and treatment of the patient is responsible for all orders for the patient. Attending, associate attending and clinical medical staff may designate members of the limited staff, or other licensed healthcare professionals with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, psychologist, podiatrist, or designated limited staff member who has the right to practice medicine, dentistry, psychology, or podiatry and who is responsible for that patient's care prior to the execution of the order. Supervising physicians may delegate to a medical staff member (who is appropriately credentialed) the ability to relay, enter, transcribe or write orders for routine laboratory, radiologic and diagnostic studies under their direction, but, in all cases, the order shall be co-signed by the supervising physician within twenty-four hours of the order being written. Community associate staff coverage may be provided by the limited staff under supervision.

- (C) Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited medical staff, or other licensed healthcare professionals with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the director of medical affairs and each chief of the clinical service where they will exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospital, or by the customary medical staff credentialing process when the provider is not an employee of the hospital. Lists of the approved titles or categories of providers shall be maintained by the director of medical affairs. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and "read back" the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider's authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by approved health care provider to whom it is given as "verbal order by _____," or "V.O. or T.O. by _____," giving the licensed healthcare practitioner's name and the time of the order, followed by the approved health care provider's signature and date, and read back in its entirety to the ordering physician, dentist, psychologist, podiatrist, designated limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. All verbal orders for DEA schedule II controlled substances, patient seclusion, or patient restraint must be

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authenticated within twenty-four hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member or other licensed healthcare professionals with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber's order entry are encouraged to be signed electronically within forty-eight hours, but must be authenticated within twenty-one days by signature by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(D) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must be developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(E) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges before becoming effective.

(F) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(G) Change of nursing service.

Level of care is defined as the type and frequency of medical and nursing interventions required to appropriately manage the medical and nursing care requirements of the patient. "Change of level of care" means official and physical movement (transfer) of a patient from an inpatient or observation care unit providing one level of care to another providing a different level of care, with or without change in attending physician, dentist, psychologist or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed or rewritten upon transfer by signature of a responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders will remain in effect until new orders are available. This should be done within eight hours of transfer.

(H) "Transfer of clinical service" means transfer of full patient responsibility from one attending physician, dentist, psychologist or podiatrist to another; the patient may remain on the same unit or a change in patient care area may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of order writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

- (1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., head and neck service."

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- (2) Transfer of service may be completed only by the receiving service writing an order to the effect "accept in transfer (or admission) to Dr., head and neck service."

Orders effective before the transfer must be renewed or rewritten upon transfer by signature of a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

- (I) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, or podiatrist and patient.

- (J) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care unit to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by signature of the responsible medical practitioner, limited staff member, or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

- (K) Do not resuscitate orders.

The order for do not resuscitate indicating that the patient should not undergo cardiopulmonary resuscitation may be written only by the attending physician or his delegate. Verbal orders for do not resuscitate will not be accepted under any circumstances. The order for do not resuscitate may be rescinded only by the attending physician or delegate and an order must be written to annul said order. Please refer to hospital policy 03-24 do not resuscitate orders for further details.

- (L) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) order designating the patient as inpatient or outpatient (observation). The appropriate level of care (ALOC) order may be written and signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privilege, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(Board approval dates: 4/6/2016, 9/2/2016)

06 Death procedures.

- (A) Every member of the medical staff shall be actively interested in securing necropsies in every death on their service. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

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- (B) The death of a patient in the hospital within twenty-four hours of admission must be reported to the proper legal authorities under the laws of Ohio.
- (C) When a necropsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.
- (D) Criteria for autopsy requests include the following:
 - (1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. Deaths occurring during surgery or within twenty-four hours of admission to the hospital are also coroner's cases, and the decision whether to autopsy is the coroner's responsibility. When the coroner elects not to perform an autopsy, a request of an autopsy shall be made pursuant to paragraph (A) of this rule.
 - (2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.
 - (3) Undiagnosed infectious disease where results may be of value in treating close contacts.
 - (4) All deaths in which the cause of death is not known with certainty on clinical grounds.
 - (5) Cases where there is question of disease related to occupational exposure.
 - (6) Organ donors (to rule out neoplastic or infectious disease).
 - (7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.
 - (8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.
 - (9) Deaths of patients who have participated in investigational therapy protocols.
 - (10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.
- (E) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval dates: 11/4/2005, 4/6/2016)

07 Emergency preparedness.

- (A) Emergency care.

Emergency care is considered to be treatment rendered to stabilize the patient prior to transport to the Ohio state university hospital's emergency department or other appropriate facility as the patient's condition dictates.

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(B) Disaster preparedness.

In case of a civil, military, natural emergency or disaster, patients may be discharged from the CHRI, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the director of medical affairs of the CHRI or the director of medical affairs designated agent, to preserve life and health, to make room for more critically ill or injured patients sent to the hospitals from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

(Board approval dates: 11/4/2005, 2/6/2009, 4/6/2016)

08 Surgical case review (tissue committees).

Surgical case review shall be performed on an on-going basis by each department regularly doing surgical procedures in conjunction with the clinical quality management committee. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement department, and be available to the director of medical affairs, the CHRI section chief, department chairperson or their designees.

(Board approval dates: 11/4/2005, 4/6/2016)

09 Tissue disposition.

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception when another suitable means of verification of the removal is routinely employed and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

- (A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
- (B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- (C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
- (D) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
- (E) Specimens known to rarely if ever show pathological change, and removal of which is highly visible postoperatively.
- (F) Teeth, provided the number including fragments is recorded in the medical record.
- (G) Specimens for gross only examination.

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- (H) Medical devices. Soft tissue accompanying medical devices may be submitted for microscopic examination if deemed appropriate by the pathologist.
- (I) Foreign bodies that are hard and cannot be decalcified. Accompanying soft tissue may be submitted for microscopic examination if deemed appropriate by the pathologist.
- (J) Portions of bone removed from feet for bunions/hammer toes, if microscopic exam deemed unnecessary by pathology.
- (K) Portions of rib removed for operative exposure only and not designated "disposal only." At the pathologist's discretion, marrow samples from such ribs may be submitted for microscopic examination.
- (L) Nasal bone and cartilage removed for deviated septum (does not apply if deviation due to neoplastic or inflammatory process). If soft tissue accompanies nasal bone and cartilage, it may be examined at pathologist's discretion.

(Board approval dates: 11/4/2005, 4/6/2016)

10 Medical records.

- (A) Each member of the medical staff shall conform to the following medical information management department policies:
 - (1) Medical record contents.
 - (a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:
 - (i) Identification demographic data including the patient's race and ethnicity.
 - (ii) The patient's language and communication needs.
 - (iii) Emergency care provided to the patient prior to arrival, if any.
 - (iv) The legal status of patients receiving mental health services.
 - (v) Evidence of known advance directives.
 - (vi) Statement of present complaint.
 - (vii) History and physical examination.
 - (viii) Any patient generated information.
 - (ix) Provisional diagnosis.
 - (x) Documentation of informed consent when required.
 - (xi) Any and all orders related to the patient's care.

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- (xii) Special reports, as those from:
 - (a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.
 - (b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.
 - (c) The radiology department.
 - (d) Consultants ~~as verified by the attending medical staff member's signature.~~
- (xiii) Medical and surgical treatments.
- (xiv) Progress notes.
- (xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
- (xvi) An intra-operative anesthesia record.
- (xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.
- (xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.
- (xix) A post anesthesia follow-up report written within forty-eight hours after surgery by the individual who administers the anesthesia.
- (xx) All reassessments and any revisions of the treatment plan.
- (xxi) Every dose of medication administered and any adverse drug reaction.
- (xxii) Every medication dispensed to an inpatient at discharge.
- (xxiii) Summary and final diagnosis as verified by the attending physician's signature.
- (xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.
- (xxv) Any referrals and communications made to external or internal providers and to community agencies.
- (xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.
- (xxvii) Memorandum copy of the death certificate when applicable.

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(2) Deadlines and sanctions.

- (a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.
- (b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.
- (c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.
- (d) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.
- (e) Office visit encounters shall be closed within ten days of the patient's visit.
- (f) All entries not previously defined must be signed within ten days of completion.
- (g) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.

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- (3) Discharges.
- (a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, a limited staff member or other licensed healthcare professional.
 - (b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for certifying the principal diagnosis, secondary diagnosis, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.
 - (c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.
 - (d) The discharge summaries must contain the following elements:
 - i. hospital course including reason for hospitalization and significant findings upon admission;
 - ii. principal and secondary diagnoses or provisional diagnosis;
 - iii. relevant diagnostic test results;
 - iv. procedures performed and care, treatment and services provided;
 - v. condition on discharge;
 - vi. medication list and medication instructions;
 - vii. plan for follow-up of tests and studies for which results are pending at discharge;
 - viii. coordination and planning for follow-up testing and physician appointments;
 - ix. plans for follow-up care and communication, and the instructions provided to the patient.
 - (e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.
 - (f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by

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the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.

- (g) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

- (a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.
- (b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days

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prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

- (a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.
- (b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.
- (c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.
- (d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019, 2/8/2022)

11 Committees.

In addition to the medical staff committees, the medical staff shall participate in the following hospital and monitoring functions: infection control, clinical quality management, safety, and disaster planning and in other quality leadership council policy groups.

Operating Room Committee

- (A) The operating room committee shall have representation from all clinical departments utilizing the operating room. Representation will include: medical director of the CHRI operating room, the section or division chief, or their designee, of: surgery, gynecologic oncology, urology, otolaryngology, radiation oncology, thoracic surgery, surgical oncology, neurological surgery, orthopedic surgery, anesthesia, and plastic surgery; epidemiology/infection control, the medical director of perioperative services for the Ohio state university, the CHRI medical director of quality, the director of perioperative services of the CHRI operating room, the manager of perioperative services, the director of admitting, the operating room coordinator, and the CHRI director of operations. The committee chair will be a CHRI surgeon selected by the nominating committee and shall serve a two-year term beginning on the first of July. The committee shall meet monthly and carry out the following duties:
- (1) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned, including allocation of operating room resources. Allocation of operating room time will be done by the director of medical affairs and approved by the operating room committee.

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- (2) Monitor quality concerns and consider problems and improvements in operating room functions brought to its attention by any of its members.
 - (3) Monitor medical staff compliance with operating room policies established for patient safety, infection control, access and throughput, and smooth functioning of the operating rooms.
 - (4) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president of health services, the director of medical affairs, and the executive director of the CHRI.
- (B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the surgical attending staff and a member of the anesthesiology staff shall be present in person for crucial periods of surgical procedures and anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

Pharmacy and Therapeutics Committee (P & T Committee)

The P & T committee shall be appointed in conformity with the medical staff bylaws and have representation from medical staff, nursing, pharmacy department, and the hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

- (A) Review the appropriateness, safety, and effectiveness of the prophylactic empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.
- (B) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.
- (C) Advise on the use and control of experimental drugs.
- (D) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.
- (E) Review all significant untoward drug reactions.
- (F) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.
- (G) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.
- (H) Create sub-committees with defined responsibilities and scope and appoint members with expertise in specified areas.

Transfusion and Isoimmunization Committee

- (A) The transfusion and isoimmunization committee has representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

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- (1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.
 - (2) Evaluate all confirmed or suspected transfusion reactions.
 - (3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.
 - (4) Review the adequacy of transfusion services to meet the needs of patients.
 - (5) Review ordering practices for blood and blood products.
 - (6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.
 - (7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.
 - (8) Keep written records of meetings, conclusions, recommendations, and actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.
- (B) Each member of the medical staff shall conform to the policies established by the transfusion committee, including the following:
- (1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.
 - (2) No medication may be added to blood or blood products.

Infection Control Committee

- (A) The committee members shall be appointed and shall also include representation from nursing, environmental services, and hospital administration. The chairperson will be a physician with experience and/or training in infectious diseases and carry out the following duties.
- (1) Oversee surveillance and institute any recommendations necessary for investigation, prevention, and containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities operated by CHRI and subject to TJC standards.
 - (2) The chairperson of the committee and the hospital epidemiologist, in consultation with the director of medical affairs of the CHRI, will take necessary actions to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

Quality Leadership Council

The quality leadership council shall consist of members appointed pursuant to the university hospital's medical staff bylaws, and shall include the senior vice president for health sciences, the dean of the college of medicine and the chairperson of the professional affairs committee of the Wexner medical center board as ex officio members without a vote, and the director of medical affairs and chief of staff as voting members. The chief quality officer shall be the chairperson of the quality leadership council. The quality leadership council shall authorize policy groups to be formed to accomplish necessary hospital and medical staff functions on behalf of the CHRI and university hospitals.

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CHRI representatives on the quality leadership council shall be appointed as provided in the CHRI bylaws.

(A) Duties include:

- (1) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery systems.
- (2) To serve as the oversight council for the clinical quality management and patient safety plan.
- (3) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(B) James Quality, Safety and Experience Council (Q-SEC).

(1) Composition.

The members shall include physicians from various clinical areas and support services, the director of clinical quality management policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

- (a) Coordinate the quality management related activities of the clinical sections or departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and immunization, and other medical staff and hospital committees.
- (b) Implement clinical improvement programs to achieve the goals of the CHRI quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.
- (c) Review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical section or department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.
- (d) Serve as liaison between the CHRI and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.
- (e) Make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the CHRI.
- (f) Hear and determine issues concerning the quality of patient care rendered by members of the medical staff and hospitals staff, make appropriate recommendations and evaluate action plans when appropriate to the director of medical affairs, the chief of a clinical section or department, or hospitals administration.
- (g) Appoint ad-hoc interdisciplinary teams to address hospital-wide quality management plan.
- (h) Annually review and revise as necessary the hospital-wide clinical quality management plan.

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- (i) Report and coordinate with the quality leadership council all quality improvement initiatives.

(C) Clinical resource utilization policy group.

(1) Composition.

The members shall include physicians from various areas and support services, the director of clinical resource utilization policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

- (a) Promote the most efficient and effective use of hospital facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.
- (b) Formulate and maintain a written resource management review plan for hospitals consistent with applicable governmental regulations and accreditation requirements.
- (c) Conduct resource management studies by clinical service or by disease entity as requested or in response to variation from benchmark data would indicate.
- (d) Report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements when the opportunity exists to improve the resource management.

(D) Clinical Practice Guideline Committee.

(1) Composition.

The members shall include physicians from various areas and support services, the director of the practice guidelines policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

- (a) Oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e. clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the CHRI. Planning should be based on the prioritization criteria approved by the leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guidelines.
- (b) To report regularly to the quality leadership council for approval of all new and periodically reviewed evidence-based medicine resources for use within the CHRI.
- (c) Oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the CHRI. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to the quality leadership council for approval. All other computerized value enhancement for approval. All other computerized

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ordersets and clinical rules should be forwarded to the quality leadership council for information.

- (d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.
- (e) Oversee ongoing education of the medical staff (including specifically limited staff) and other appropriate hospital staff on the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.
- (f) Regularly report a summary of all actions to the quality leadership council.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 4/6/2016, 5/18/2021, 8/15/2023)

12 Standards of practice.

- (A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is an emergency situation, where waiting might compromise the patient's safety.
- (B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.
- (C) Inpatients must be seen daily by an attending physician, with no exceptions, to provide the opportunity of answering patient and family questions.

(Board approval dates: 4/8/2011, 4/6/2016)

13 Mechanism for changing rules and regulations.

- (A) These rules and regulations may be amended pursuant to rule 3335-111-12 of the Administrative Code.
- (B) Amendments so accepted shall become effective when approved by the Ohio state university Wexner medical center board.
- (C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.
- (D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval dates: 11/4/2005, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

14 Adoption of the rules and regulations.

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These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in successive order to the following: the professional affairs committee of the Wexner medical center board if it meets prior to the next scheduled Wexner medical center board meeting, and the Wexner medical center board.

(Board approval dates: 7/7/2006, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

15 Sanctions.

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee of the CHRI. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval dates: 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)