



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

Updated September 2, 2016

**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 provide research, education, and service programs to benefit the mental, physical, and environmental health of the citizens of the state of Ohio, the region, the nation, and the world and to facilitate dissemination of medical knowledge to health professionals and the public.

(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)

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

Updated September 2, 2016

**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 community associate attending 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

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

Updated September 2, 2016

ethics of 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. Except for community associate staff, 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 (list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance and access and communication guidelines. 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) Exclusion of any medical staff member or allied health professional 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 lapse of clinical privileges at the CHRI as of the effective date of the exclusion or suspension. If the medical staff member's or allied health professional's participation in these programs is fully reinstated, the affected medical staff member or allied health professional shall be eligible to apply for membership and clinical privileges at that time. It shall be the duty of all medical staff members and allied health professionals to promptly inform the director of medical affairs or medical director of credentialing of any action taken, or the initiation of any process, which could lead to such action taken by any of these programs.
- (5) Board certification.

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

Updated September 2, 2016

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. Waiver of these eligibility criteria is 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.
  - (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. 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.
- (6) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.
  - (7) Applicants for community associate attending medical staff category, practicing in a CHRI unit at another hospital, must have and maintain clinical privileges and active medical staff membership at that hospital.
  - (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), (A)(5) or (A)(7) of this rule shall not be entitled to request a hearing and appeal in accordance

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

Updated September 2, 2016

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 (F)(6)(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 twenty-four 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 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. In the case of community associate attendings, receipt of the positive evaluation provided by the clinical department chief in the primary hospital in which they hold privileges is required. 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.

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

Updated September 2, 2016

(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:
  - (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

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

Updated September 2, 2016

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;
  - (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.
  - (f) DEA registrations, when required for the exercise of requested clinical privileges;
  - (g) Graduation from an accredited professional school, when applicable;
  - (h) Successful completion or record of post professional graduate medical education;

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

Updated September 2, 2016

- (i) Board certification or, active candidacy for board certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
  - (j) Information from the national practitioner data bank and other JCAHO approved sources;
  - (k) Verification that the applicant has not been excluded from any federally funded health care program; and
  - (l) Complete disclosure by the applicant of all past and current claims, suits, verdicts, and settlements, if any.
  - (m) Completion of criminal history check by the Ohio state university medical center security department.
  - (n) Completion of the Ohio state university medical center drug testing.
  - (o) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
  - (p) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.
  - (q) 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 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 section chief. 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 section chiefs 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.



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

Updated September 2, 2016

- (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.
- (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

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

Updated September 2, 2016

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 section chief.

- (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 section chief, 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 twenty-four months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. At least ninety days prior to the end of the medical staff member' 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.
  - (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 section chief 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;

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

Updated September 2, 2016

- (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.
  - (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 section chief. 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 section chief 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 section chief 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

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

Updated September 2, 2016

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 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 section chief.
- (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.

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

Updated September 2, 2016

- (G) Resumption of clinical activities following a leave of absence:
- (1) A member 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 current appointment. A member of the medical staff 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 shall be placed on immediate medical leave of absence until such time the member 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 shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.
  - (2) The member 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 treating physician or the committee for practitioner health that might have a bearing on the medical staff member'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 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 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 in such event, the member 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)

**3335-111-05 Peer review and corrective action**

- (A) Informal peer review.

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. 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 sections or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee. The practitioner evaluation committee chair, or his or her designee, will consult with the affected medical staff member and obtain information or opinions from knowledgeable

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

Updated September 2, 2016

persons within the medical center as well as external peer review consultants, pursuant to criteria outlined in these bylaws. 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. 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:

- (1) The matter warrants no further action;
- (2) 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 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
- (3) 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 section chief, 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

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

Updated September 2, 2016

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;
  - (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 within thirty days its findings and recommendations for action to the appropriate clinical department chief and notice given to the section chief. 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.
- (6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall, within seven days, 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 have ten days to approve or to 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; section chief; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

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

Updated September 2, 2016

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 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.



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

Updated September 2, 2016

(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 section chief, 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 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 section chief, 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.

- (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 such suspension, the medical staff member shall be deemed to have voluntarily terminated 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 be immediately and automatically suspended until such time as the exclusion, debarment, or prohibition is lifted.
- (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,

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

Updated September 2, 2016

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 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.

(Board approval dates: 9/1/1993, 5/2/1997, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2011, 4/8/2011, 11/7/2014, 11/6/2015)

**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 receives notice of a proposed action by the chief executive officer or the director of medical affairs that will adversely affect reappointment as a member of the medical staff or the exercise of clinical privileges, the staff member shall be entitled to an adjudicatory hearing.
  - (2) 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 be 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 that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

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

Updated September 2, 2016

(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.
- (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

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

Updated September 2, 2016

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 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

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

Updated September 2, 2016

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.

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

Updated September 2, 2016

- (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 section chief, 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)

**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, community associate 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 years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, 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, section chief, 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.

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

Updated September 2, 2016

- (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.
- (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 section chief); 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.
  - (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 he or she is providing care, or arrange a suitable alternative for such care and supervision.

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

Updated September 2, 2016

- (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 committees of which he or she is a member unless otherwise provided by resolution of the staff, clinical department or committee and approved by the medical staff administrative committee.
- (d) The associate attending staff member may not vote on amendments to the bylaws.

(3) Responsibilities:

Associate attending staff members shall:



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

Updated September 2, 2016

- (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 section chief 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.
- (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.

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

Updated September 2, 2016

- (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) Community associate attending staff.

(1) Qualifications:

The community associate attending staff shall consist of those applicants who do not have faculty appointments in any of the academic units of the Ohio state university and who are licensed in the state of Ohio and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code. All applications for appointment and reappointment to the community associate attending staff shall be made to the chief executive officer for initial evaluation. The chief executive officer shall consult with the clinical department chief and the chairperson of the appropriate academic department and when appropriate may refer each application for completion of the appointment procedure in accordance with pertinent requirements of paragraph (E) or (F) of rule 3335-111-04 of the Administrative Code. The approval of the clinical department chief and the academic department chairperson or section chief shall not be required.

(2) Prerogatives:

The community associate attending staff members may:

- (a) Provide consulting services to James patients.
- (b) Admit patients when the primary diagnosis is cancer or cancer-related.
- (c) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (d) Attend all meetings of the medical staff as non-voting members and attend any and all medical staff or hospital education programs. The community associate attending staff member may not hold elected office in the medical staff organization except to serve as a non-voting, ex-officio member of medical staff committees if appointed pursuant to these rules.

(3) Responsibilities:

The community 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.

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

Updated September 2, 2016

- (b) Retain responsibility within their care area of professional competence for the continuous care and supervision of each patient for whom the member 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 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 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.

(G) 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.
- (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.

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

Updated September 2, 2016

- (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.

(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.

(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.

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

Updated September 2, 2016

- (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, clinical attending or community associate 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 reappointment, 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 academic department or training program and approved by the director of medical affairs and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement. 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:
- Failure to meet reasonable expectations may result in sanctions including but not limited to probation, lack of reappointment, suspension or termination. Termination of limited staff member status shall result in automatic termination of the limited staff member's residency or fellowship 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.

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

Updated September 2, 2016

- (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, clinical attending or community associate 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, clinical attending or community associate 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, clinical attending or community associate 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, clinical attending or community associate attending medical staff member or the director of the training program.

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

(I) 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

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

Updated September 2, 2016

affairs, who may accept, reject or modify the recommendation. The decision of the director of medical affairs shall be final.

(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 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.

(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 section 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 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

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

Updated September 2, 2016

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 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, and approval by the director of medical affairs. The director of medical affairs, acting as a member and on behalf of the Wexner medical center board, has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. 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 not be granted for a period not to exceed one hundred twenty days.



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

Updated September 2, 2016

- (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 twenty-four 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. A member of the medical staff who is a doctor of medicine or osteopathy shall:
  - (i) 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 diagnosis or therapeutic interventions defined by the medical staff.

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

Updated September 2, 2016

- (b) 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.
  - (c) 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.
- (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

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

Updated September 2, 2016

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.
  - (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.

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

Updated September 2, 2016

- (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;
  - (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the CHRI;

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

Updated September 2, 2016

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

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

Updated September 2, 2016

- (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 CHRI 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 CHRI 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:
- 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.

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

Updated September 2, 2016

- (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)

**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. 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 be responsible to the chief executive officer, the executive vice president for health sciences, the CHRI hospital board, and the 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.

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

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

Updated September 2, 2016

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.

- (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 for administrative and operational issues and has an independent reporting relationship to the executive vice president for health sciences regarding quality data and patient safety events. The chief quality officer works collaboratively with clinical leadership of the medical center, including 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) Associate physician-in-chief.

The associate to the physician-in-chief oversees the alignment of clinical service lines within the cancer program. The associate serves at the direction of the physician-in-chief to further the global cancer mission at OSU. The role functions as a key strategic liaison between the physician-in-chief, chief of staff and the medical staff to strategically grow the footprint of the cancer program. The associate physician-in-chief reports to the physician-in-chief of the James.

- (G) Medical director of surgical services.

The chief of surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the chief of 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 chief of 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 chief of surgical services reports to the physician-in-chief of the James.

- (H) The sections.

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

There are four clinical sections: medical oncology, surgical oncology, radiation oncology and pathology. Appointment to a specific section is based on the clinical specialty of the applicant for



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

Updated September 2, 2016

medical staff membership. Each section is headed by a section chief who has the responsibility to oversee all research and clinical activities conducted by members of the section. Specifically, the section chief 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 section; the orientation and continuing surveillance of the professional performance of all section members; recommendation for space and other resources needed. The section chief is appointed by the chief executive officer.

(I) 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;
- (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;

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

Updated September 2, 2016

- (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 independent 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)

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

(A) Chief of staff.

The chief of staff shall:

- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.

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

Updated September 2, 2016

- (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 jointly with the physician-in-chief and chief of staff-elect for approval by the CHRI medical staff administrative committee.
- (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.

(C) Delegates at-large.

There shall be two delegates at-large that are members of the medical staff. Each delegate at large shall be a member of the medical staff administrative committee and shall serve on those committees of the medical center board as appointed by the chairperson of the medical center board.

(D) Qualifications of officers.

- (1) Officers must be members of the attending or associate 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, section chiefs, medical directors, associate and/or assistant medical 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 written or 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.
- (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.

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

Updated September 2, 2016

- (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 April.
  - (5) Candidates for the office of chief of staff-elect will be listed and each attending or associate attending staff member may vote for one. Candidates for the at-large positions will be voted upon as a group. Each voting member of the medical staff may vote for two at-large candidates. The two candidates with the highest number of votes will be elected. A majority of the votes is not 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 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 of staff.

(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)

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

Medical staff committees.

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

Updated September 2, 2016

- (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, section chiefs of medical oncology, radiation oncology, surgical oncology and pathology; division chiefs of hematology, gynecologic oncology, otolaryngology, surgical oncology, thoracic surgery, orthopaedic oncology and urology; clinical department chiefs of anesthesia, plastic surgery 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, and CCC director for cancer control. 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 or section head is a member by leadership position, he or she will also fulfill the role of division or section chief 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 associate director for professional education, the CHRI chief nursing officer, 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, the executive vice president for health sciences and the associate director for medical staff affairs.
- (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. The chief executive officer may invite any member of staff as the chief executive officer's representative at a meeting or to attend any meeting with the chief executive officer.
- (d) All members of the committee shall attend, either in person 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

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

Updated September 2, 2016

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.
  - (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.

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

Updated September 2, 2016

- (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) 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.

(4) 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 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 biennially 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;

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

Updated September 2, 2016

- (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/section), 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:
- (a) This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (A)(3) of rule 3335-111-09 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



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

Updated September 2, 2016

- (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 or associate attending staff pursuant to paragraph (A)(3) of rule 3335-111-09 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)(3) of rule 3335-111-09 of the Administrative Code.

(2) Duties:

- (a) To consider issues of licensed independent 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.

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

Updated September 2, 2016

- (f) To educate CHRI hospital and the medical staff about illness and impairment recognition issues, including at risk criteria specific to licensed independent practitioners.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, diagnostic radiology, radiation oncology, palliative medicine and pathology, the cancer liaison physician and nonphysician 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.
- (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:

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

Updated September 2, 2016

- (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.

(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.

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

Updated September 2, 2016

- (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) Professionalism consultation committee.
- (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)

**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
    - (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 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
  - (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

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

Updated September 2, 2016

- 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 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 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 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:

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

Updated September 2, 2016

- (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)

**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 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.

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

Updated September 2, 2016

(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 printed or secure electronic ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least thirty 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 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)



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

Updated September 2, 2016

**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. A special meeting 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)