Northside Hospital & Tampa Bay Heart Institute

NORTHSIDE HOSPITAL & TAMPA BAY HEART INSTITUTE

MEDICAL STAFF BYLAWS

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TABLE OF CONTENTS

1. ONE: DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

1.1. DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), and Medical Director.

Administrator: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An action that adversely affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

Allied Health Professional (AHP): An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP). An Allied Health Professional shall have an active sponsoring physician, in the same field, who is a member in good standing of the Medical Staff. Applicants to the Allied Health Professional Staff shall pay an application fee of $250.00 and shall be required to pay a re-appointment fee of $150.00.

Applicant: An individual who has submitted a Complete Application for appointment, reappointment or clinical privileges.

Approved Program: As applies to Medical Schools, Dental Schools, Podiatry Schools, or to residency, refers to programs, which have been approved by the American Medical Association, the American Osteopathic Association, the American Podiatry Medical Association, or the American Dental Association.

Board Certified: Refers to granting of certification, in a physician's chosen field of practice, by a Specialty Board recognized by the American Medical Association, the American Osteopathic Association, or the American Podiatry Medical Association.

Board of Directors: The governing body of the Corporation, herein referred to as the "Directors" unless otherwise specifically stated.

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. The term may also refer to a committee of the Board of Trustees that has been delegated specific governance duties and authority. It is the "governing body" as described in the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

Chief of Staff: A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

Contacts: Are defined as admissions, procedures and consults.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement with the Hospital.

Corporate Management: The officers of the Corporation with authority and responsibility for the Hospital.

Corporation: The legal owner of the Hospital, Galencare, Inc. d.b.a. Northside Hospital & Heart Institute**.**

CPCS: The Clinical Patient Care System, used to electronically document patient care

Criminal Conviction: Conviction of, or a plea of guilty or *nolo contendere* for, any felony or misdemeanor related to the practice of a health care profession, Federal Health Care Program fraud or abuse, third-party reimbursement, or controlled substances.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license and in accordance with individually granted clinical privileges.

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Disruptive Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual's own ability to practice competently. Such conduct may include rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

Section: A clinical sub grouping of members of a Medical Staff department in accordance with their subspecialty or specialized practice interest, as specified in these Bylaws.

Executive Committee/Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Ex Officio: Service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the MEC and Board and incorporated into these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

Good Standing: The term "good standing" means a staff member who, during the current term of appointment, has maintained qualifications for Medical Staff membership and assigned staff category, has met attendance and participation requirements, is not in arrears in dues payment or the completion of medical records, and has not received a suspension or restriction of membership or privileges.

Governing Body: The Board of Trustees of the Hospital or a committee of the Board of Trustees, which has been delegated specific authority and responsibility, and appointed by the Board of Directors.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.A §11101 et seq.

Healthcare Professional: An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Northside Hospital & Heart Institute, 6000 49th Street North, St. Petersburg, FL 33709. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DMP).

Medical Staff: The formal organization of all categories of Practitioners designated by the Board to be eligible for Medical Staff membership. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DMP). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

Medical Staff Office: The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for

clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Office is accountable to Administration. The documents maintained by the Medical Staff Office are the property of the Hospital.

Medical Staff Year: The period from January 1 to December 31 of each year.

Medico-Administrative Practitioner: A Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction.

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership are in good standing pursuant to these Bylaws.

Membership: The approval granted by the Board to a qualified Practitioner to be a member of the Medical Staff of the Hospital.

Non-Privileged Practitioner: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Oral and Maxillofacial Surgeon, Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education.

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Allied Health Professionals, written procedures for peer review are part of these Bylaws.

Physician: An individual who has been educated and trained in the practice of medicine, and who holds a current license as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Podiatrist: An individual who holds a current license as a Doctor of Podiatric Medicine (DMP).

Practitioner/Licensed Independent Practitioner (LIP): Individuals who provide direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DMP).

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment and individual character.

Qualified Physician: A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments and Sections as approved by the MEC and Board of Trustees.

Sanctioned: Any challenges to any licensure or registration, or voluntary or involuntary relinquishment of such; voluntary or involuntary termination of medical staff membership; voluntary or involuntary limitation, reduction, or loss of clinical privileges and circumstances defined in these Bylaws under which an individual is to report to the Hospital his/her involvement in a professional liability action (at least final judgments and settlements involving a practitioner).

Sexual Harassment: Unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions, or verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment.

Special Notice: Written notification sent by certified mail, return receipt requested.

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Florida.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance.

1.2. CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

2. ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES

2.1. NAME

The name of the Medical Staff shall be the "Medical Staff of Northside Hospital & Heart Institute."

2.2. PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff are:

2.2.1. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.

2.2.2. To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

2.2.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.

2.2.4. To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assurance, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.

2.2.5. To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.

2.2.6. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;

2.2.7. To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;

2.2.8. To provide a means for communication and conflict resolution with regard to issues of mutual concern to the Staff, Administration, and Board;

2.2.9. To participate in identifying community health needs and establishing appropriate institutional goals;

2.2.10. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, quality assurance, performance improvement, and peer review.

2.2.11. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.

2.2.12. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies.

2.2.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.

3. ARTICLE THREE: APPOINTMENT/REAPPOINTMENT

3.1. NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints. Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws. No person shall admit patients or provide services to Hospital patients as a Practitioner or AHP unless he/she is appointed to the Staff or has been granted clinical privileges in accordance with the provisions outlined in these Bylaws. Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual's Staff category or as are afforded to AHPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. A person may be a member of the Staff without having any clinical privileges, as in the case of an Honorary Staff member. The granting of clinical privileges does not automatically confer Staff membership or appointment. A person may be granted clinical privileges without Staff membership or appointment, as in the case of an Allied Health Professional. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:

3.1.1. LICENSURE

The applicant must possess a current license in the State of Florida for the practice of medicine, dentistry, podiatry or an allied health practice. Proof of licensure in the form of a copy of the license shall be included as part of the application for membership. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.

3.1.2. CONTROLLED SUBSTANCE REGISTRATION

To have prescribing privileges, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration. Proof of registration in the form of

a copy of the registration certificate(s) shall be included as part of the application. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA. and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.

3.1.3. PROFESSIONAL EDUCATION AND TRAINING

The applicant must have graduated from an accredited School of Medicine, Dentistry, Podiatry, or school appropriate to their profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school. An applicant Practitioner must also have successfully completed a residency program in the field of specialty for which the Practitioner requests clinical privileges and shall be board certified, board qualified as defined by the specialty board for his/her specialty, or comparably qualified as defined by the Medical Executive Committee. At the time of reappointment to the Medical Staff or renewal or revision of clinical privileges, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested. Participation in continuing education shall be considered when making decisions about clinical privileges.

3.1.4. CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and past facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).

3.1.5. CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and past facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Section and Department Chairperson(s).

3.1.6. PROFESSIONAL ETHICS AND CHARACTER

The applicant shall agree to abide by the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant's practice if it is not listed. The applicant shall also agree to abide by the Code of Conduct of HCA - The Healthcare Company, and the code of ethical behavior of this Hospital.

3.1.7. HEALTH STATUS/ABILITY TO PERFORM

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment does not adversely affect the applicant's ability to

perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

3.1.8. COMMUNICATION SKILLS

The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

3.1.9. PROFESSIONAL LIABILITY INSURANCE

The applicant shall maintain professional liability insurance coverage for the clinical privileges requested equal to that required by the State of Florida for each claim and equal to that required by the State of Florida in aggregate, as a qualification for initial appointment and to cover the term of the individual's Medical Staff membership or clinical privileges (e.g., "claims-made" coverage).

3.1.10. ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person.

3.1.11 OSTEOPATHIC PHYSICIAN

An osteopathic physician subscribes to and utilizes the distinctive osteopathic approach in the provision of care as appropriate.

3.2. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the Staff review requests for Staff membership and/or particular clinical privileges in connection with appointment, reappointment or otherwise on the basis of the following:

3.2.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital.

3.2.2. EXCLUSIVE CONTRACTS

The Board may determine, in the interests of quality of patient care and as a matter of policy, that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.

3.2.3. MEDICAL STAFF DEVELOPMENT PLAN

The Board may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan, which shall be based on identification by the Hospital of the patient, care needs within the population served.

3.2.4. EFFECTS OF DECLINATION

Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not

entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

3.3. EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.

3.4. NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, race, religion, creed, or national origin.

3.5. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

3.5.1. Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;

3.5.2. Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;

3.5.3. Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;

3.5.4. Discharge such Medical Staff, Department, Section, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty;

3.5.5. Participate in necessary training and utilize the CPCS to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;

3.5.6. Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

3.5.7. Participate in peer review, quality assurance, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;

3.5.8. Participate in continuing education to maintain clinical skills and current competence.

3.5.9. Notify and update the Medical Staff and Hospital immediately upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);

3.5.10. Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate; and,

3.5.11. Perform such other responsibilities as the Hospital or the Medical Staff may require.

3.6. TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges shall be for a period of one year (12 months), and subject to extension for a total period not to exceed two years (24 months). Reappointments shall be for a period not to exceed two years (24 months). In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

3.7. CREDENTIALS VERIFICATION AND APPLICATION PROCESSING PROCEDURES

3.7.1. NEW APPOINTMENT PRE-APPLICATION PROCESS

Upon receipt of a request to apply for Staff membership or clinical privileges, the Medical Staff Office shall screen the person requesting Staff membership or clinical privileges before an application is sent. The person requesting Staff membership or clinical privileges shall be asked to supply documentation used to determine his/her eligibility to apply for membership or clinical privileges. The following information is required to determine eligibility:

3.7.1.1. Current license to practice in this State;

3.7.1.2. Current controlled substance registration, if prescribing medications;

3.7.1.3. Proof of professional liability insurance;

3.7.1.4. Geographic location of office and residence (where applicable); and,

3.7.1.5. Medicare Provider UPIN or evidence that application for a Medicare UPIN has been made.

3.7.1.6. If the individual is able to provide the above listed evidence of qualifications, he/she shall be provided with an application form. Failure to provide the above listed evidence shall result in ineligibility to apply for Staff membership or clinical privileges and shall not be considered an adverse action, and the individual shall not be entitled to any hearing or appeal rights under these Bylaws. Such determination will not result in the filing of a report with the state professional licensing board or with the National Practitioner Data Bank.

3.7.2. APPLICATION

A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given a copy of these Bylaws, the Medical Staff and applicable departmental Rules and Regulations, and applicable Hospital policies. At least six months prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges.

3.7.3. BURDEN ON APPLICANT

The applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the

responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities are submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Office shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Failure to provide a complete application, as defined in these Bylaws, within six months after being provided with an application form for appointment, reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Office shall provide special notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application form shall include, without limitation:

3.7.3.1. Identifying information, including name, social security number, date of birth, any aliases, a passport-type photograph, any biometric identification required to verify identification or background, and addresses of office and residence.

3.7.3.2. Evidence of current licensure and information regarding past licensure in any healthcare profession;

3.7.3.3. Evidence of controlled substance registration(s), both federal DEA and state, if applicable;

3.7.3.4. For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;

3.7.3.5. For reappointments or renewal of clinical privileges, the applicant's participation in continuing education, specifically as related to the clinical privileges requested;

3.7.3.6. The names of at least two peers who will provide information as to the applicant's experience, current competence, judgment, conduct, ethics and character, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal (and therefore not a current partner in medical practice, spouse or other family member). For an applicant for reappointment, the applicant's department chairperson may serve as one of the peers, if he/she is a peer of the applicant;

3.7.3.7. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;

3.7.3.8. Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;

3.7.3.9. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;

3.7.3.10. Medicare Provider UPIN;

3.7.3.11. Information as to any current, possible, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;

3.7.3.12. Accurate and complete disclosure with regard to the following queries:

3.7.3.12.1. Whether the applicant has any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration;

3.7.3.12.2. Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;

3.7.3.12.3. Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,

3.7.3.12.4. Whether the applicant has ever been subject to a criminal conviction, as defined in these Bylaws, or whether any such action is pending.

3.7.3.13. A statement from the applicant that he/she agrees to abide by the ethical code and standards governing his/her profession;

3.7.3.14. A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.7;

3.7.3.15. A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them;

3.7.3.16. A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;

3.7.3.17. A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including for a new applicant a permission to conduct a criminal background check, and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

3.7.3.18. A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.

3.7.3.19. In the case of applicants for initial appointment to the Medical Staff, a signed Professional Review Organization Acknowledgement Statement.

3.7.3.20. Physicians, other Practitioners, and Allied Health Professionals will sign an Information Security Agreement at the time CPCS access is granted, and during the reappointment process. Completed Agreements will be maintained in the individual's credentials file.

3.7.3.21. Except for applicants for Staff membership in the Honorary category, all applications must include a specific written request for clinical privileges using prescribed forms.

3.7.3.22. As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to provide to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, including but not limited to any change in licensure or DEA status or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a PRO citation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.7.4. VERIFICATION PROCESS

Upon the receipt of a completed application form, the Medical Staff Office shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Office shall consult primary sources of information about the applicant's credentials, where feasible. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Hospital and the verification is documented. The Medical Staff Office shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed; meaning that all information has been provided and verified, as defined in these Bylaws. The following information shall be verified for all applicants for appointment, reappointment, or clinical privileges, except as specified:

3.7.4.1. Current licensure shall be verified through the applicable state licensure boards for all applicants. For new applicants, current and past licensure in other states shall also be verified through those applicable state licensure boards.

3.7.4.2. For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism.

3.7.4.3. For individuals requesting prescribing privileges, state controlled substance registration shall be verified through the applicable state agency.

3.7.4.4. For new applicants, completion of medical school or other post-graduate programs appropriate to the applicant's healthcare profession shall be verified through the school's registrar's office and/or through the ECFMG in the case of a foreign medical school graduate.

3.7.4.5. For new applicants, internship, residency, or other applicable postgraduate training shall be verified through the program's registrar's office or program director's office.

3.7.4.6. For new allied health professionals, a criminal background check shall be obtained.

3.7.4.7. Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.

3.7.4.8. The OIG Sanction Report and the GSA List shall be checked to ensure that the applicant is not listed.

3.7.4.9. Professional liability insurance shall be verified through the insurance carrier.

3.7.4.10. The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.7, and as part of information requested from the

applicant's peers, or in the case of an applicant for reappointment, from the applicant's Department Chairperson.

3.7.4.11. Letters from the applicant's peers shall be obtained. Two peer letters of reference shall be required for initial applicants. One letter of reference shall be required for applicants for reappointment or renewal of clinical privileges; the Department Chairperson may serve as the second peer reference in such cases unless the Chairperson or Chief of Staff is not a peer, and then two peer references letters shall be required.

3.7.4.12. For reappointments or the renewal of clinical privileges, information regarding the applicant's number of cases, treatment results and conclusions drawn from quality assurance, performance improvement activities, and other information regarding the applicant's history of meeting the criteria for membership or clinical privileges, as defined in these Bylaws, shall be assembled for review. Relevant applicant-specific information from organization performance improvement activities shall be considered and compared to aggregate information when evaluating professional performance, judgment, and clinical or technical skills at the time of reappointment, or renewal or revision of clinical privileges.

3.7.4.13. Specialty board certification shall be verified through consultation with the American Board Medical Specialties (ABMS), the American Board of Osteopathic Specialties (ABOS), the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS), or a comparable specialty board, as applicable.

3.7.4.14. With regard to new applicants for Staff membership or clinical privileges, or applicants for reappointment who are not active at the Hospital, other facility affiliations shall be verified through correspondence with the facilities' Medical Staff offices.

3.7.5. APPLICATION PROCESSING

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:

3.7.5.1. Department Report: The Medical Staff Office shall make available the application and all supporting materials to the Chairperson of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the Section to be assigned if appropriate to the applicant's practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chairperson, the Chief of Staff or the Department Vice-Chairperson shall make the evaluation and recommendations. Following the Department Chairperson(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the department report(s) shall be within 30 days of receipt of a complete application.

3.7.5.2. Credentials Committee Action: The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials; the report of the Department Chairperson and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse

recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the department report, to be within 30 days. **[**

3.7.5.3. Medical Executive Committee Action: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials, the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Medical Executive Committee action shall be at the next regular meeting of the committee following receipt of the Credentials Committee report, to be within 30 days.

3.7.5.4. Effect of MEC Action

3.7.5.4.1. Deferral: The MEC may defer action where the deferral is not solely for the purpose of causing delay. Action by the MEC to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such action to defer the application shall be followed with a subsequent favorable or adverse recommendation. The MEC may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.

3.7.5.4.2. Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Board for action at the Board's next regular meeting.

3.7.5.4.3. Adverse Recommendation: If the recommendation of the MEC is adverse under Article Seven of these Bylaws, the Chief of Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.

3.7.5.5. Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the MEC. The action of the Board shall be taken within 30 days after receiving a recommendation from the MEC.

3.7.5.5.1. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.

3.7.5.5.2. If the Board does not adopt the recommendation of the MEC, the Board may either refer the matter back to the MEC with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the

matter is referred back to the MEC, the MEC shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.

3.7.5.5.3. If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.

3.7.5.5.4. All decisions to appoint shall include a delineation of clinical privileges (with exception of appointees to the Honorary staff category), the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.

3.7.5.5.5. Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal were held, Article Seven shall govern notice of the Board's final decision.

3.8. CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall be reported to the Credentials Committee and actions shall be taken as provided in these Bylaws:

3.8.1. Current licensure;

3.8.2. Drug Enforcement Administration registration;

3.8.3. Professional liability insurance;

3.8.4. Specialty board certification, if applicable; and,

3.8.5. Not excluded, debarred, or otherwise ineligible to participate in the Federal Health Care Program. (The OIG Sanction Report and the GSA List shall be checked every six months.)

3.9. ASSISTANCE WITH EVALUATION

The Board, the CEO, the Staff or any committee involved in the review or evaluation of applications for Staff membership or clinical privileges, or the ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may:

3.9.1. Obtain the assistance of an independent consultant or others;

3.9.2. Consider the results of performance improvement or quality assurance activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;

3.9.3. Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

3.9.4. Request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

3.9.5. Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

3.10. PERFORMANCE PROFILING

The Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board shall direct and enforce the establishment of a performance improvement and quality assurance program with the requisite quality assurance processes. Processes shall include the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall have their roles and responsibilities regarding performance improvement and quality assurance delegated and defined within these Medical Staff Bylaws, Rules and Regulations and Hospital policies, procedures and plans for the measurement and improvement of the quality and appropriateness of patient care.

The Medical Staff measurement, analysis and improvement activities shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and profiling established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and departments of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity including the Health Care Quality Improvement Act.

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual's professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual's clinical performance shall also be included. The Hospital may use epidemiological and statistical methods to compare practice patterns of individuals on dimensions of cost, service use, or quality (including process and outcome) of care. The Hospital may consider resource consumption and quality of care by an individual through an examination of patterns of health care delivery. Profiles may be constructed for individuals or groups of individuals based on Hospital, geographic, specialty, and type of practice or other characteristics. Performance profiles, including the results of performance-based measures such as patterns of treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual's:

3.10.1. Quality and appropriateness of patient care, including patient care outcomes;

3.10.2. Malpractice and professional liability experience;

3.10.3. Utilization of Hospital resources and facilities;

3.10.4. Timely, legible and accurate completion of patient medical records;

3.10.5. Attendance and participation in Medical Staff committee and department meetings;

3.10.6. Attainment and maintenance of board certification;

3.10.7. Maintenance of required levels of professional liability insurance coverage;

3.10.8. Attainment of continuing education requirements; and,

3.10.9. Attribution to sentinel events, medical errors or other risk occurrences.

The Board of Trustees shall be responsible for assuring the use of clinical and other measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assurance shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assurance process.

3.11. PROVISIONAL STATUS AND PROCTORING

Initial appointments and initial granting of clinical privileges shall be for a period of at least one year (12 months), and subject to extension for a total period not to exceed two years (24 months). Each individual subject to provisional status may be proctored by one or more appropriate member(s) of the Medical Staff as determined by chairperson of the department to which the individual is affiliated. The provisional status individual shall be proctored for the number and type of cases, procedures or treatments specified by the clinical department as appropriate to the patient care and services provided by department members. The proctored care shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. The proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed twelve (12) months. Advancement shall be based upon a favorable recommendation of the individual's department chairperson based on the chairperson's review of the proctoring reports, and a favorable recommendation of the Credentials Committee and MEC, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the MEC and the Board, an individual's failure to complete the required number of proctored cases shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

3.12. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

3.13. MEDICO-ADMINISTRATIVE OFFICERS

3.13.1. DEFINED

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

3.13.2. STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall delineate the clinical privileges of Medico-Administrative officers who request to admit and/or treat patients.

3.13.3. EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

In the event a Practitioner who is employed by or has contracted with the Hospital, or otherwise serves in a Medico-Administrative position pursuant to a contract, is subject to removal from office through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

An adverse action, as defined in these Bylaws, against a medico-administrative practitioner for clinical reasons or for violation of these Bylaws shall be subject to the hearing and appeal procedures in Article Seven of these Bylaws. Pursuant to any specific provisions of the contract, such adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract shall control.

3.14. INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.14.1. QUALIFICATIONS AND SELECTION

Practitioners ("Contract Practitioners") providing clinical services shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges of Contract Practitioners to admit and/or treat patients.

3.14.2. EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and

clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

3.15. LEAVE OF ABSENCE

A Medical Staff member may request a voluntary leave of absence from the Staff by submitting a written notice to the Medical Executive Committee. The request must state the approximate period of leave desired, which may not exceed one year, and include the reasons for the request. During the period of leave, the Practitioner shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the member requesting the leave. A leave of absence

shall be granted for members in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a member has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence shall be granted for the following reasons:

3.15.1. MEDICAL LEAVE OF ABSENCE

A Medical Staff member may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment. If a member is unable to request a medical leave of absence because of a physical or psychological condition, the Chief of Staff or chairperson of the Practitioner's department may submit the written notice on his/her behalf. A certified letter will be sent to the Practitioner informing him/her of this action. Reinstatement of membership status and clinical privileges may be subject to production of evidence by the Practitioner that he/she has the ability to perform the clinical privileges requested.

3.15.2. MILITARY LEAVE OF ABSENCE

A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations. Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.15.3. EDUCATIONAL LEAVE OF ABSENCE

A Medical Staff member may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.

3.15.4. PERSONAL/FAMILY LEAVE OF ABSENCE

A Medical Staff member may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors Without Borders/USA") or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.15.5. TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any

3.15.6. earlier time, the Medical Staff member may request reinstatement of Medical Staff membership and clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, Sections 3.7.3.1 – 3.7.3.21, or if changes have occurred, a detailed description of the nature of the changes. If so requested, the Staff member shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. The Chief of Staff will forward the request for reinstatement to the member's department chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. An adverse decision regarding reinstatement of Staff membership or

renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.15.7. FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff. A request for Medical Staff membership subsequently received from a member deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

3.16. 3.16 RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignation of Medical Staff membership shall be granted for a Practitioner in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's Department Chairperson, the Medical Executive Committee, and the Board shall review letters of resignation. Upon acceptance of the resignation by the Board, the Practitioner will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or incompetence, a report shall be submitted to the state professional licensing board for reporting to the NPDB, as required by federal law.

3.17. ACTIONS INVOLVING AN IMPAIRED PRACTITIONER OR OTHER INDIVIDUAL WITH CLINICAL PRIVILEGES

The Hospital has an obligation to protect patients and others from harm. In this regard, the Medical Staff and Hospital leaders have designed a process to provide education about health issues related to Practitioners and others with clinical privileges. The process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition. Therefore, it is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An "Impaired Individual" is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

3.17.1. SELF-REPORTING

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.

3.17.1.1. An oral or preferably, a written report shall be given to the Chief Executive Officer, the Chief of Staff, the chairperson of the individual's Medical Staff department, and/or the chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Credentials Committee.

3.17.2. THIRD PARTY REPORTS

If a Medical Staff member, Allied Health Professional, Hospital employee, patient or the patient's family, or other person witnesses warning signs of impairment they should report the incident. Medical Staff members and others, as appropriate, shall be educated about illness and impairment recognition issues specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.17.2.1. An oral or, preferably, a written report shall be given to the Chief Executive Officer, the Chief of Staff, the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may be impaired. The person making the report does not need to have proof of the impairment, but must state the facts leading to the concern.

3.17.2.2. If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further investigation, the recipient of the report may:

3.17.2.2.1. Meet personally with the individual under investigation or designate another appropriate person to do so; and/or,

3.17.2.2.2. Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Credentials Committee.

3.17.3. INVESTIGATION

Following a written request to investigate, the Credentials Committee shall investigate the concerns raised and any and all incidents that led to the belief that the individual may be impaired. The Committee's investigation may include, but is not limited to, any of the following:

3.17.3.1. A review of any and all documents or other materials relevant to the investigation;

3.17.3.2. Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the individual's health status are related to the performance of the individual's clinical privileges and Medical Staff duties and are consistent with proper patient care or the operations of the Hospital;

3.17.3.3. A requirement that the individual under investigation undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the individual's clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital;

3.17.3.4. A requirement that the individual under investigation undergo urine drug screening, serum alcohol/drug level testing or other appropriate testing.

3.17.3.5. The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the individual's clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the

Committee feels that the individual may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.17.4. OUTCOME OF INVESTIGATION

Based on all of the information it reviews as part of its investigation, the Credentials Committee shall determine:

3.17.4.1. Whether the individual is impaired, or what other problem, if any, is affecting the individual under investigation;

3.17.4.2. If the individual is impaired, the nature of the impairment and whether it is classified as a disability;

3.17.4.3. If the individual's impairment is a disability, whether a reasonable accommodation can be made for the individual's impairment such that, with the reasonable accommodation, the impaired individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;

3.17.4.4. Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,

3.17.4.5. Whether the impairment could negatively impact the quality of care or the health or safety of the impaired individual, patients, Hospital employees, physicians or others within the Hospital. Such negative impact must involve a risk of substantial harm based upon medical analyses and/or other objective evidence.

3.17.4.6. If the Committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the impaired individual, so long as that arrangement would neither impose an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer shall be kept informed of attempts to work out a voluntary agreement before it becomes final and effective.

3.17.4.7. If the Committee determines that there is no reasonable accommodation that can be made as described above, or if the Committee cannot reach a voluntary agreement with the impaired individual, the Credentials Committee shall make a recommendation and report to the Board of Trustees through the Medical Executive Committee, as appropriate to the action to be taken. If the Committee's recommendation would provide the impaired individual with a right to a hearing as described in the Medical Staff Bylaws, the impaired individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws.

3.17.4.8. The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual's credentials file and further monitoring or other

follow-up shall be at the discretion of the Medical Executive Committee or the Credentials Committee.

3.17.4.9. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.17.5. TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.17.5.1. An individual with an impairment shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological impairment such that the condition is under sufficient control.

3.17.5.2. The Medical Staff is not required to extend membership or privileges to an individual with an impairment, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.17.5.3. Upon sufficient proof that the individual who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired individual for reinstatement of Medical Staff membership or clinical privileges.

3.17.5.4. In considering an impaired individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

3.17.5.5. The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual's medical or psychological treatment. The impaired individual must authorize the release of this information. That letter shall state:

3.17.5.5.1. Whether the impaired individual is participating in the program or treatment;

3.17.5.5.2. Whether the impaired individual is in compliance with all of the terms of the program or treatment plan;

3.17.5.5.3. Whether the impaired individual attends AA/NA meetings regularly (if appropriate);

3.17.5.5.4. To what extent the impaired individual's behavior and conduct are monitored;

3.17.5.5.5. Whether, in the opinion of the treating physician, the impaired individual is rehabilitated or the medical/psychological impairment is under control;

3.17.5.5.6. Whether an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,

3.17.5.5.7. Whether, in the opinion of the treating physician, the impaired individual is capable of resuming practice and providing continuous, competent care to patients.

3.17.5.6. The Medical Staff has the right to require opinion(s) from other physician consultants of its choice.

3.17.5.7. Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:

3.17.5.7.1. The impaired individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;

3.17.5.7.2. The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.

3.17.5.8. The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chief of Staff, the Chairperson of the Credentials Committee, or the pertinent Department Chairperson.

3.17.5.9. As a condition of reinstatement, the impaired individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three, Section 3.7.7 of these Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.

3.17.5.10. If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.

3.17.5.11. If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

3.17.5.12. All requests for information concerning the impaired individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

4. ARTICLE FOUR: CATEGORIES OF THE MEDICAL STAFF

4.1. CATEGORIES

The Staff shall include active, associate, courtesy, medico administrative, and honorary categories. At the time of appointment and at the time of each reappointment, the Medical Staff member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.

4.2. LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state of federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

4.3. ACTIVE STAFF

4.3.1. REQUIREMENTS FOR ACTIVE STATUS

The active staff category shall consist of Practitioners who regularly admit, and maintain 12 patient contacts per year which will be reviewed by the Department chair or his/her designees prior to advancement or re-appointment, (contacts are defined as admissions, procedures or consults) or personally provide services other than written consultation, to patients in the Hospital and who are located (primary or satellite office and permanent or temporary residence) within a reasonable distance and/or travel time, ("reasonable" to be determined by the Board based on the Practitioner's specialty and scope of care at the Hospital) to provide continuous care to their patients. Hospital-based Practitioners who do not admit patients may be members of the active Medical Staff if otherwise qualified.

4.3.2. PREROGATIVES OF ACTIVE STATUS

Except for active staff members on provisional status, members of the active staff shall be eligible to vote, hold office within the Medical Staff organization. Any active staff member may attend Medical Staff and department meetings and serve on committees of the Board, Medical Staff or Hospital. Subject to availability of beds, any member of the active staff may admit patients without limitation, except as otherwise provided in these Bylaws or the Rules and Regulations, and exercise such clinical privileges as are granted to him/her.

4.3.3. OBLIGATIONS OF ACTIVE STATUS

Each member of the active staff shall discharge the basic obligations of staff members as required in these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assurance and performance improvement activities of the Hospital; attend Medical Staff and department meetings; and perform such further duties as may be required of him/her under these Bylaws or Rules and

Regulations. Active Staff members are required to maintain at least 12 patient contacts per year. These recognized contacts shall be admissions, procedures, consultations, or surgeries.

4.4 ASSOCIATE STAFF

4.4.1 REQUIREMENTS FOR ASSOCIATE STATUS

The Associate Staff shall consist of Practitioners who have evidenced an interest in attending patients at the Hospital and who are located (primary or satellite office and permanent or temporary residence) within a reasonable distance and/or travel time, .
Initial appointees to the Medical Staff shall serve as Associate Staff Members for one year. During this period, Members of the Associate Staff shall have their professional and clinical performance and activities observed by their Department Chairperson or his/her representative, ("reasonable" to be determined by the Board based on the Practitioner's specialty and scope of care at the Hospital) to provide continuous care to their patients. The Associate Staff member will maintain a minimum of 12 patient contacts for the associate year. Contacts are described as admissions, procedures, consultations, or surgeries. Hospital-based Practitioners who do not admit patients may be members of the associate Medical Staff if otherwise qualified.

4.4.2 PREROGATIVES OF ASSOCIATE STATUS

At the end of one year, Members of the Associate Staff must qualify for advancement to the Active Staff. If the patient encounter numbers are not met the practitioner will be placed on Associate Staff Status for an additional year. At the end of the second Associate year the practitioner will advance to Active Staff or at the discretion of the Board may be appointed to the Courtesy Staff or may have their staff membership and clinical privileges terminated as a voluntary resignation based on lack of demonstrated evidence of patient care in the hospital.

4.4.3. OBLIGATIONS OF ASSOCIATE STATUS

Members of the Associate Staff shall pay dues; shall not be eligible to vote or hold office; but are encouraged to serve on Medical Staff Committees, except the Executive Committee, Credentials Committee, and Nominating Committee. Members of the Associate Staff shall attend General Medical Staff and department (or section thereof) meetings as provided in these Bylaws and as may be amended. An Associate may vote in a Department (or section thereof) Committee of which he/she is a member.

Associate Staff members may serve on the Emergency Department On-Call Schedule.

Associate Staff Members may serve as consultants.

Associate Staff members must have successfully completed their residency which is pertinent to their specialty in an "approved program, or be certified by the appropriate specialty board. Individuals in the practice of general dentistry are excluded from this requirement since appropriate residencies are not available.

4.5 COURTESY STAFF

4.5.1 REQUIREMENTS FOR COURTESY STATUS

The courtesy staff category shall consist of Practitioners who only occasionally admit patients to the Hospital or who provide consultation to other staff members. The Board may, in its discretion, establish a maximum number of patient admissions that may be made by members of the courtesy staff.

4.5.2 PEROGATIVES OF COURTESY STATUS

Members of the courtesy staff shall not be eligible to vote or hold office within the Medical Staff organization. A courtesy staff member may serve on committees of the Board, Medical Staff or Hospital and may attend Medical Staff and department meetings. Subject to availability of beds, each member of the courtesy staff may admit patients within any established limitations, except as otherwise provided in these Bylaws or the Rules and Regulations, and exercise such clinical privileges as are granted to him/her.

4.5.3 OBLIGATIONS OF COURTESY STATUS

Each member of the courtesy staff shall discharge the basic obligations of staff members as required in these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations. CONSULTING STAFF

4.6 REQUIREMENT FOR CONSULTING STAFF STATUS

The Consulting Staff shall consist of Practitioners of recognized professional ability who provide a service not readily available on the Active Staff.. These Practitioners are not required to live or practice in proximity of the Hospital. Consulting Staff Members must meet the standards prescribed for active Staff Members.

These practitioners shall be in good standing of the Medical Staff at another healthcare facility where they are currently actively practicing, unless exempted of this requirement by the Medical Executive Committee and the Board of Trustees.

4.6.1 PEROGATIVES OF CONSULTING STAFF STATUS

Consulting Staff may write orders, but may not admit patients to the hospital. Consulting Staff may not perform surgical procedures as the sole surgeon of record unless approved by the Chair of the Department of Surgery, Chief of Staff, or the Medical Executive Committee. Members of the Consulting Staff may attend meetings of the medical staff and committees, however, may not vote or hold office.

4.6.2 OBLIGATIONS OF THE CONSULTING STAFF

Members of the Consulting Staff must conform to the Bylaws and Rules and Regulations of the Medical Staff and Governing Body and the current hospital polices as written and amended from time to time. Consulting Staff shall cooperate in peer review and performance improvement process.

4.7 HONORARY STAFF

4.7.1 REQUIREMENTS FOR HONORARY STATUS

The honorary staff category shall consist of Practitioners retired from medical practice who are recognized for their noteworthy contributions to the health and medical sciences, or previous long-standing service to the Hospital.

4.7.2 PREROGATIVES OF HONORARY STATUS

Members of the honorary staff shall not be eligible to vote, hold office within the Medical Staff organization, or serve on any committees. An honorary staff member may attend Medical Staff or department meetings. No member of the honorary staff may admit patients to the Hospital or hold clinical privileges.

4.7.3 OBLIGATIONS OF HONORARY STATUS

Each member of the honorary staff shall abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

4.8 CHANGE IN STAFF CATEGORY

4.8.1 Pursuant to a request by the medical staff member, upon a recommendation by the credentials committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a member consistent with the requirements of the bylaws. The board shall approve any change in category.

4.9 MEDICAL STUDENTS, INTERNS, RESIDENTS, AND FELLOWS

The terms, "medical students," "interns," "residents," and "fellows," (hereinafter referred to collectively as "house staff") as used in these Bylaws, refer to Practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

4.9.1 Applicable provisions of the professional licensure requirements of this state;

4.9.2 A written affiliation agreement between the Hospital and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a house staff Practitioner, equal to

the required amount of the State of Florida for each claim and equal to the required amount of the State of Florida in aggregate; and,

4.9.3 The protocols established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a house staff Practitioner's authority, mechanisms for the direction and supervision of a house staff Practitioner, and other conditions imposed upon a house staff Practitioner by this Hospital or the Medical Staff.

4.9.4 The protocols must delineate the roles, responsibilities, and patient care activities of residents, interns and medical students, including which type of resident may write patient care orders, under which circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanism through which resident directors and supervisors make decisions about resident's progressive involvement and independence in delivering patient care.

4.9.5 While functioning in the Hospital, house staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the CEO or the Chief of Staff. House staff Practitioners may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. House staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Sections, or committees, but shall have no voting rights.

4.9.6 As defined in Section 4.7 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., "moonlighting" or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.9.7 Resident, Intern and Medical Student supervisors must met the following specifications:

Be licensed independent practitioners

Hold Clinical privileges that reflect the patient care responsibilities given to the residents.

4.10 ALLIED HEALTH PROFESSIONALS

The term, "Allied Health Professional" (AHP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although AHPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP). An Allied Health Professional shall have an active sponsoring physician, in the same field, who is a member in good standing of the Medical Staff.

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, operating room nurses and technicians, perfusionists, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. These categories of dependent healthcare professionals are *not considered Allied Health Practitioners.* Although a Medical Staff member may provide employment, sponsorship and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff member, *these Bylaws shall not apply to such dependent healthcare professionals*. Dependent healthcare professionals are listed here only to distinguish them from AHPs.

A Medical Staff member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an AHP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

4.10.1 REQUIREMENTS FOR ALLIED HEALTH PROFESSIONALS

As permitted by state law, AHPs shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. The terms of the accountability of the AHP to the Medical Staff member and the terms for supervision of the AHP by a Medical Staff member shall be documented in a sponsorship agreement between the AHP and the sponsoring Medical Staff member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

4.10.1.1 Name of the sponsoring Medical Staff member and name of any alternative sponsoring Medical Staff members;

4.10.1.2 Completed sponsoring Medical Staff member's evaluation;

4.10.1.3 Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff member(s);

4.10.1.4 Signed agreement by the sponsoring Medical Staff member(s) to provide required supervision and accept responsibility for the patient care services provided by the AHP.

4.10.1.5 An applicant for Affiliate privileges must document his/her professional mental and physical competency and be duly licensed and trained to provide such services. The applicant shall provide services within the scope of privileges granted, not to exceed lawful authority and within all Bylaws, Rules and Regulations and policies of the Hospital and Medical Staff.

4.10.2 PEROGATIVES OF ALLIED HEALTH PROFESSIONALS

AHP's shall not be eligible to vote, hold office within the Medical Staff organization, or serve on any committees. An AHP may attend Medical Staff or Department/Section meetings if invited. No AHP may admit patients to the Hospital.

4.10.3 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS:

Each AHP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

4.10.4 ALLIED HEALTH PROFESSIONAL – AUTOMATIC TERMINATION

Allied Health Professionals who are employed by a physician and are sponsored by the same physician can no longer treat patients in the facility when their employment with that physician is terminated.

5 ARTICLE FIVE: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Every Practitioner or Allied Health Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board. The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this state or any certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department or Section. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Section Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

5.2 DELINEATION OF PRIVILEGES

5.2.1 APPLICATION

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Except for Honorary members who by virtue of their category are not eligible for clinical privileges, every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.5.

5.2.2 ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

5.2.3 ADDITIONS TO CLINICAL PRIVILEGES

A request by an individual with clinical privileges for additional clinical privileges or modifications in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. In processing such a request, the National Practitioner Data Bank will be queried, and the response used by the Medical Staff and the Board in considering the request.

5.2.4 BASIS FOR PRIVILEGE DETERMINATION

Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references, information from the applicant's current or past facility affiliations, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought. The criteria for

granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients.

The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of performance profiling, as provided for in Article Three of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges.

Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three of these Bylaws.

5.2.5 DELINEATION

Requests for clinical privileges shall be processed pursuant to the procedures outlined in these Bylaws. Clinical privileges shall be delineated on an individual basis. The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients whom have been admitted.

5.2.6 NEW/TRANSPECIALTY PRIVILEGES

Any request for clinical privileges that are either new to the Hospital or that overlap more than one Department shall initially be reviewed by the Credentials Committee. The Credentials Committee shall review the need for, and appropriateness of a new procedure or service. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that all individuals with such clinical privilege provide the same level of quality of patient care. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The approval of the Medical Executive Committee and the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

5.2.7 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions.

5.2.8 USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

A Practitioner who is not a Medical Staff member and who has not been granted clinical privileges may order outpatient ancillary services providing the following requirements are met:

5.2.8.1 The Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospital;

5.2.8.2 If medications are being ordered, the Practitioner shall provide proof of current, unrestricted DEA registration.

5.2.8.3 The Hospital shall ensure that the Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter;

5.2.8.4 The Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electro diagnostic testing, or medications.

5.2.8.5 The Practitioner's ordering practices shall be subject to the supervision of the medical director of the Hospital department performing the test or service, or the Chief of Staff. The Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.

All diagnostic tests that require an interpretation by a Practitioner with a delineated clinical privilege to do so shall be subject to interpretation by a member of the Medical Staff with such privileges and the interpretation shall be provided to the non-privileged Practitioner.

5.2.9 LIMITED LICENSURE PRACTITIONERS

Requests for clinical privileges from limited licensure Practitioners (e.g., Licensed Independent Practitioners who are not physicians) shall be processed in the manner and based on the same conditions as for any applicant for clinical privileges. Due to the limitations imposed by the Practitioner's license, a Medical Staff member who is a qualified physician is required to be responsible for the care of a patient admitted by a limited licensure Practitioner with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and that is not specifically within the scope of practice of the limited licensure Practitioner, as defined by the Medical Staff and permitted by state law. All patients admitted by a limited licensure Practitioner should have a history and physical examination by a qualified physician as defined in these Bylaws, who shall also agree to provide any needed medical or psychiatric care to the patient during the hospitalization, should the need arise. The limited licensure Practitioner shall be responsible for securing the services of such physician prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

5.2.9.1 Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

5.2.9.2 Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry.

5.2.9.3 An oral and maxillofacial surgeon who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education, and who has been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the clinical privilege to perform the medical history and physical examination.

5.2.9.4 Other Licensed Independent Practitioners who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff in the Rules & Regulations or policy) diagnostic or therapeutic interventions.

5.2.9.5 In addition, as permitted by state law and by the Medical Staff as specified in policy, individuals who are not Licensed Independent Practitioners may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified

physician shall retain accountability for the patient's medical history and physical examination

5.2.10 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the applicant's qualifications or competence, an applicant whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the National Practitioner Data Bank via the state professional licensure agency.

5.3 TEMPORARY PRIVILEGES

For Temporary Privileges, Locum Tenens, Disaster and Emergency Privileges, refer to Rules and Regulations of the Medical Staff Section XV.

6

6. ARTICLE SIX: CORRECTIVE ACTIONS

6.1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assurance or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief of Staff, appropriate department chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or to deal with the matter in

accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity or conduct that gave rise to the request. The investigation shall be conducted pursuant to the peer review provisions in these Bylaws.

6.2 ALTERNATIVES TO CORRECTIVE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws. Alternatives to corrective action may include:

6.2.1 Informal discussions or formal meetings regarding the concerns raised about conduct or performance;

6.2.2 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

6.2.3 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

6.2.4 Suggestions that the individual seek continuing education, consultations, or other assistance in improving performance;

6.2.5 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

6.2.6 Requirements to seek assistance for an impairment, as provided in these Bylaws.

6.3 SUMMARY SUSPENSION OR RESTRICTION

Whenever a Staff member's conduct or the conduct of an individual with clinical privileges appears to require that immediate action be taken to protect the life or well-being of a patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the health or safety of any patient, prospective patient, or other person, the Chief of Staff, appropriate department chairperson, or Chief Executive Officer may impose a summary suspension or restriction on the clinical privileges of the individual. Unless otherwise stated, such suspension or restriction shall become effective immediately upon imposition, and the person responsible for imposing the suspension or restriction shall promptly give written notice to the Chief Executive Officer and the Medical Executive Committee. In addition, the affected individual shall be provided with a written notice of the action within one day of imposition. This initial notice shall include a summary of facts and issues regarding the individual's conduct that led to the summary suspension or restriction, and shall not substitute for the notice required in Article Seven. When the individual being suspended or restricted is a Practitioner, the Chief of Staff or the chairperson of the Practitioner's department shall arrange for alternative medical coverage of a suspended Practitioner's patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Allied Health Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

6.3.1 MEDICAL EXECUTIVE COMMITTEE ACTION

Upon notice of a summary suspension or restriction, the Medical Executive Committee shall direct that an investigation be conducted within fourteen (14) days as provided in Article Six, Section 6.3 of these Bylaws. The Medical Executive Committee shall also review the circumstances leading to the summary suspension or restriction and may determine, as a result of the review, to continue, modify, or terminate the summary suspension or restriction pending the outcome of the investigation.

6.4 INVESTIGATION/PEER REVIEW PROCESS

Peer review may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The Quality/Peer Review Committee or the Medical Executive Committee may conduct such an investigation, or the Medical Executive Committee may assign the task to a Medical Staff officer, department, Section, ad hoc committee or other organizational component. External third parties may be utilized in the investigation process as provided in these Bylaws. The investigation may involve an interview with the practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing. The investigation shall include:

6.4.1 Conformance to the peer review procedures outlined in Article Ten, Section 10.4.13.

6.4.2 As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;

6.4.3 A report of the investigation, including all material evidence, and a recommendation to the Medical Executive Committee.

6.5 ACTION ON INVESTIGATION REPORT

As soon as practicable after the conclusion of an investigation, the Medical Executive Committee shall determine an appropriate action and make a recommendation to the Board of Trustees unless a corrective action that fits the definition of an adverse action is recommended. The Medical Executive Committee shall take one or more of the following actions, without limitations:

6.5.1 Determine that there was no credible evidence warranting corrective action;

6.5.2 Use one of the alternatives to corrective action, as outlined in Article Six, Section 6.2 of these Bylaws;

6.5.3 Use a corrective action that fits the definition of an adverse action, which shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Seven.

6.6 AUTOMATIC SUSPENSION OR TERMINATION

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, the individual shall be immediately and automatically be suspended from practicing in the Hospital by the CEO, and his/her staff membership may be automatically terminated. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

6.6.1 LICENSURE

If an individual's license to practice is revoked or suspended by a state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her staff membership shall be automatically terminated.

6.6.2 CONTROLLED SUBSTANCE REGISTRATION

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, or if an individual fails to maintain a current unrestricted registration, he/she shall be automatically suspended from practicing in the Hospital.

6.6.3 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.6.4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital:

6.6.4.1 Becoming an Ineligible Person; or,

6.6.4.2 A criminal conviction.

6.6.5 MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual's delinquent records are completed.

6.6.6 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, the individual's membership and clinical privileges shall be automatically terminated. The individual may not re-apply until twenty-four months have passed.

6.7 CRIMINAL ARREST

In the event that an individual is arrested for alleged criminal acts, an immediate investigation into the circumstances of the arrest shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Seven.

6.8 AUTOMATIC RESIGNATION

6.8.1 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired.

7 ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES

7.1 OVERVIEW

Fair hearing and appellate review procedures shall be used in addressing adverse actions involving those who are applying for Medical Staff membership, for existing Medical Staff members, and for other individuals applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.10.4 of these Bylaws.

7.2 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1 AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed staff or exclusive contract or in accord with a Medical Staff development plan.

7.2.2 MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the individual's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

7.2.3 AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws.

7.2.4 REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Staff membership, but rather is an obligation. No hearing or appeal rights under these

Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

7.2.5 HOSPITAL POLICY DECISION

The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (e.g., closing a department or service, or a physical plant change) that adversely affects the Staff membership or clinical privileges of any Staff member or other individual.

7.3 HEARING RIGHTS

7.3.1 ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws if recommended by the MEC, or if taken by the Board contrary to a favorable recommendation by the MEC under circumstances where a right to hearing exists. The following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

7.3.1.1 Denial of initial staff appointment;

7.3.1.2 Denial of reappointment;

7.3.1.3 Suspension of staff membership;

7.3.1.4 Revocation of staff membership;

7.3.1.5 Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;

7.3.1.6 Denial of requested clinical privileges;

7.3.1.7 Involuntary reduction in clinical privileges;

7.3.1.8 Summary suspension or restriction of clinical privileges, as defined in Article Six, Section 6.3;

7.3.1.9 Revocation of clinical privileges; or,

7.3.1.10 Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.3.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.1 shall promptly be given special written notice of such action. Such notice shall:

7.3.2.1 State the reasons for an adverse recommendation or action, with enough specifics to allow response;

7.3.2.2 Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

7.3.2.3 Specify the number of days following the date or receipt or notice within which a request for a hearing must be submitted.

7.3.2.4 State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.

4.3.3.1. State a summary of the Practitioner's rights at the hearing.

7.3.2.5 State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

7.3.3 REQUEST FOR HEARING

A Practitioner shall have 30 days following his/her receipt of a notice pursuant to Section 7.3.2 to file a written request for a hearing. Such requests shall be delivered

to the Chief Executive Officer either in person or by certified or registered mail. A timely request shall temporarily suspend sanctions or recommended discipline until the hearing/appeal process is completed unless the Practitioner was summarily suspended under Article Six of the Bylaws.

7.3.4 FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

7.3.4.1 An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board.

7.3.4.2 An adverse action by the Board shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board.

7.4 HEARING PREREQUISITES

7.4.1 SPECIAL WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff or to the Trustees, depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent a special written notice stating the following:

7.4.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;

7.4.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;

7.4.1.3 The Practitioner involved has the right:

7.4.1.3.1 To representation by an attorney or other person of the Practitioner's choice;

7.4.1.3.2 To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

7.4.1.3.3 To call, examine, and cross-examine witnesses;

7.4.1.3.4 To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court law; and

7.4.1.3.5 To submit a written statement at the close of the hearing.

7.4.1.4 Upon completion of the hearing, the Practitioner involved has the right:

7.4.1.4.1 To receive the written recommendation of the panel, including a statement of the basis for the recommendations; and,

7.4.1.4.2 To receive a written decision of the health care entity, including a statement of the basis for the decision.

7.4.1.5 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

7.4.2 APPOINTMENT OF HEARING COMMITTEE

7.4.2.1 By Medical Staff: A hearing occasioned by an adverse recommendation of the MEC shall be conducted by an ad hoc hearing committee appointed by the Chief of Staff and composed of five members of the Medical Staff. One of the members so appointed shall be designated as Chairman. The Chairman will preside over the hearing. No member may serve who is involved in the controversy, or who has investigated any of the issues, or is in direct economic competition with the involved

Practitioner, or is a member of the Medical Executive Committee or Board of Trustees.

7.4.2.2 By Board: A hearing occasioned by an adverse action of the Board shall be conducted by a hearing committee appointed by the Chairman of Board and composed of five Medical Staff members. One of the appointees to the committee shall be designated as Chairman. The Chairman will preside over the meeting. No member may serve who is involved in the controversy, or who has investigated any of the issues, or is in direct economic competition with the involved Practitioner, or is a member of the Medical Executive Committee or Board of Trustees.

7.4.2.3 Service on Hearing Committee: The hearing committee members shall gain no direct financial benefit from the outcome of the case, shall not have acted as accusers, investigators, fact finders or initial decision makers in the matter, and shall not have actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the hearing committee.

7.4.2.4 Challenges for Cause: The Practitioner may question hearing committee members regarding potential bias, prejudice or conflict of interest and challenge any member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairman, or if challenged, the Chief of Staff, shall decide the validity of such challenges. His/her decision shall be final.

7.5 HEARING PROCEDURE

7.5.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.3.4.

7.5.2 PRESIDING OFFICER

The Chairman of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

7.5.3 HEARING OFFICER APPOINTMENT AND DUTIES

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Chief of Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing.

7.5.4 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice. The MEC or the Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to represent the facts in support of its adverse recommendation or action, and to examine witnesses.

7.5.5 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

7.5.5.1 Call and examine witnesses;

7.5.5.2 Introduce exhibits;

7.5.5.3 Cross-examine any witness on any matter relevant to the issues;

7.5.5.4 Impeach any witness;

7.5.5.5 Rebut any evidence; and

7.5.5.6 Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

7.5.6 PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing committee is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the Chairman's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

7.5.7 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

7.5.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. Court reporters shall be present if requested by any party (at the expense of the requesting party).

7.5.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairman to a date agreeable to the hearing committee only by stipulation between the parties or upon a showing of good cause.

7.5.10 PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

7.5.11 RECESSES AND ADJOURNMENT

The hearing committee may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.5.12 SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the actions taken.

7.6 HEARING COMMITTEE REPORT AND FURTHER ACTION

7.6.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire hearing committee, and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing.

7.6.2 ACTION ON HEARING COMMITTEE REPORT

Within 30 days after receipt of the written report of the Hearing Committee, the MEC or Board, as the case may be, shall consider the report and affirm, modify or reverse its recommendations or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the Chief Executive Officer. The MEC or Board, as the case may be, may also request an oral report by the Chairman of the hearing committee during the 30-day review period.

7.6.3 NOTICE AND EFFECT OF RESULT

7.6.3.1 Notice: The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by special notice, to the Chief of Staff, to the MEC and to the Board.

7.6.3.2 Effect of Favorable Result:

7.6.3.2.1 Adopted by the MEC: If the MEC's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the MEC's recommendation in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall within 31 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.6.3.2.2 Adopted by the Board: If the Board's initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

7.6.3.3 Effect of Adverse Result for Practitioner: If the result of the MEC or of the Board continues to be adverse to the Practitioner in any of the respects listed in Section 7.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 7.7.1.

7.7 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

7.7.1 REQUEST FOR APPELLATE REVIEW

A Practitioner shall have 30 days following his/her receipt of a notice pursuant to Section 7.6.3.2.1 or 7.6.3.3 to file a written request for an appellate review. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

7.7.2 FAILURE TO REQUEST APPELLATE REVIEW

A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 7.7.1 above waives any right to such review. Such waiver shall constitute acceptance of the recommendation or action, which shall become immediately effective. The matter shall be considered closed.

7.7.3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall not be less than 30 days from the date of notice to the Practitioner of the time, place and date of the review. The time for the appellate review may be extended or expedited by the appellate review body for good cause.

7.7.4 APPELLATE REVIEW BODY

The appellate review shall be conducted by an appellate review committee of five (5) members of the Board appointed by the Chairman of the Board. At least three members of the appellate review committee must be active members of the Medical Staff. If a committee is appointed, one of its members shall be designated as Chairman. No person shall serve on the appellate review committee if that person has served on the hearing committee in the same case or if that person is in direct economic competition with the Practitioner.

7.8 APPELLATE REVIEW PROCEDURE

7.8.1 NATURE OF PROCEEDINGS

The proceedings by the review committee shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The proceedings shall be restricted to reviewing whether the Medical Staff Bylaws were followed and whether substantial evidence to support the recommendation is documented. The appellate review committee shall also consider the written statements, if any, submitted pursuant to Section 7.8.2 and such other material as may be presented and accepted under Sections 7.8.4 and 7.8.5.

7.8.2 WRITTEN STATEMENTS

The Practitioner seeking the review and the MEC may submit a written statement detailing the findings of fact, conclusions and procedural matters with which the party agrees or disagrees, and the reasons for such agreement or disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review committee through the Chief Executive Officer at least three (3) days prior to the scheduled date of the appellate review, except if such time limit is waived by the appellate review committee.

7.8.3 PRESIDING OFFICER

The Chairman of the appellate review committee shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

7.8.3.1 Challenges for Cause: The Practitioner may challenge any member of the appellate review committee for any cause, which would indicate bias or predisposition. The Chairman, or if challenged, the Vice-Chairman shall decide the validity of such challenges. His/her decision shall be final.

7.8.4 ORAL STATEMENT

The appellate review committee, in its sole discretion, may allow the parties or their representatives to appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions asked him/her by any member of the appellate review committee.

7.8.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters of evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the appellate review committee, and, as the appellate review committee deems appropriate, only if the party requesting consideration of the matter or evidence demonstrates that it could not have been discovered in time for the initial hearing. The requesting party shall

provide, through the Chief Executive Officer, a written, substantive description of the matter or evidence to the appellate review committee and the other party at least three (3) days prior to the scheduled date of the review.

7.8.6 POWERS

The appellate review committee shall have all the powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

7.8.7 PRESENCE OF MEMBERS AND VOTE

A majority of the appellate review committee must be present throughout the review and deliberations. If a member of the appellate review committee is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

7.8.8 RECESSES AND ADJOURNMENT

The appellate review committee may recess the review proceedings and reconvene the review proceedings at predetermined time for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

7.8.9 ACTION TAKEN

The appellate review committee may, as decided by a majority vote of its members, affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within 30 days in accordance with its instructions. Within 30 days after receipt of such recommendation after referral, the appellate review committee shall take action.

7.8.9.1 Appellate Review Committee Decision: The appellate review committee's decision is the final decision in the matter and will become effective when ratified by the Board.

7.9 FINAL DECISION OF THE BOARD

7.9.1 BOARD ACTION

Within seven (7) days after the conclusion of the appellate review, the Board shall render a final decision in the matter in writing and shall send notice thereof to the practitioner, to the Chief of Staff, and to the MEC.

7.10 GENERAL PROVISIONS

7.10.1 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

7.10.2 RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article Twelve in these Bylaws relating to immunity from liability in all matters relating thereto.

7.10.3 CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law. Therefore, all records promulgated hereunder will be maintained in accordance with policies concerning maintaining privileged records.

7.10.4 HEARING AND APPEAL PROCEDURES FOR ALLIED HEALTH PRACTITIONERS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Allied Health Professionals - AHPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for AHPs:

7.10.4.1 Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the AHP subject to the adverse recommendation or action. The notice shall state that the AHP has 30 days in which to request a hearing. If the AHP does not request a hearing within 30 days, the AHP shall have waived right to a hearing.

7.10.4.2 Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, the Chief of Staff or another officer of the Medical Staff, and a peer of the AHP. None of the panel members shall have had a role in the adverse recommendation or action.

7.10.4.3 Rights: The AHP subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses.

7.10.4.4 Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.10.4.4.1 A determination favorable to the AHP shall be reported in writing to the body making the adverse recommendation or action.

7.10.4.4.2 A determination adverse to the AHP shall result in notice to the AHP of the right to appeal the decision to the Chairman of the Board.

7.10.4.5 Final Decision: The decision of the Chairman of the Board shall be final.

7.10.5 EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s).

8 ARTICLE EIGHT: MEDICAL STAFF OFFICERS

8.1 ELECTED OFFICERS OF THE STAFF

8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, the Chief of Staff-Elect, the Secretary-Treasurer, and the Immediate Past Chief of Staff.

8.1.2 QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office.

8.2 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

8.2.1 TERM OF OFFICE

Each officer shall serve a two (2) year term [1]. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise

[1] See minutes from December General Staff meeting 2008

unable to complete the term. At the end of the Chief of Staff's term, the Chief of Staff-Elect shall automatically assume that office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

8.2.2 ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

8.3 ATTAINMENT OF OFFICE

8.3.1 NOMINATION

At least forty-five (45) days before the annual Staff meeting of each year, the Nominating Committee shall convene and submit to the Chief of Staff one or more qualified nominees for the offices of Chief of Staff-Elect and Secretary-Treasurer. The Nominating Committee shall report the names of the nominees to the Staff at least thirty (30) days before the annual meeting. Nominations may also be made by petition signed by at least ten percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least fourteen (14) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

8.3.2 ELECTION

Voting at the annual meeting shall be by secret written ballot (by active staff members only), and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.

8.3.3 BOARD APPROVAL/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Section officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assurance/performance improvement activities. The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assurance/performance improvement activities. Such activities shall have the following characteristics:

8.3.3.1 The activities such leaders undertake shall be performed on behalf of the Hospital;

8.3.3.2 The activities shall be performed in good faith,

8.3.3.3 That any professional review action shall be taken:

8.3.3.3.1 In the reasonable belief that the action was in the furtherance of quality health care;

8.3.3.3.1.1 After a reasonable effort to obtain the facts of the matter;

8.3.3.3.1.2 After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

8.3.3.3.1.3 In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.

8.3.3.4 The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

8.3.3.5 Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

8.4 VACANCIES

8.4.1 WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status in good standing.

8.4.2 HOW FILLED IN THE OFFICE OF THE CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff, then the Chief of Staff-Elect shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of Chief of Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Chief of Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

8.4.3 HOW FILLED IN THE OFFICES OF THE CHIEF OF STAFF-ELECT, SECRETARY-TREASURER OR THE IMMEDIATE PAST CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a Chief of Staff and Chief of Staff-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election.

8.5 RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.5.1 RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

8.5.2 REMOVAL

Any Medical Staff officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

8.5.2.1 Failure to perform the duties of office;

8.5.2.2 Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

8.5.2.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

8.5.2.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

8.5.2.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

8.5.3 RECALL FROM OFFICE

Any Medical Staff officer may be recalled from office, with or without cause. Recall of a Medical Staff officer may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in medical Staff-Elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending

the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

8.6 RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

8.6.1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the Chief of Staff are to:

8.6.1.1 Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

8.6.1.2 Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

8.6.1.3 Serve as ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;

8.6.1.4 Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;

8.6.1.5 Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

8.6.1.6 Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

8.6.1.7 Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the CEO and the Board, and serve as an ex-officio member of the Board, with a vote;

8.6.1.8 Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

8.6.1.9 Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,

8.6.1.10 Perform all other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board.

8.6.1.11 Recommend clinical privileges for each member of the Medical Staff or other individual requesting clinical privileges;

8.6.1.12 Conduct surveillance of the professional performance of all individuals who have clinical privileges.

8.6.2 CHIEF OF STAFF-ELECT

The Chief of Staff-Elect shall perform the duties of the Chief of Staff in the absence or temporary inability of the Chief of Staff to perform. The Chief of Staff-Elect shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Board.

8.6.3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

8.6.3.1 Maintain a roster of Medical Staff members;

8.6.3.2 Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

8.6.3.3 Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff;

8.6.3.4 Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,

8.6.3.5 Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.4 IMMEDIATE PAST CHIEF OF STAFF

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Chief of Staff shall serve as an advisor and mentor to the Chief of Staff, shall participate as a member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Chief of Staff.

9 ARTICLE NINE: CLINICAL DEPARTMENTS AND SPECIALTY SECTIONS

9.1 DESIGNATION

9.1.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be organized into clinical departments. The Medical Staff Departments are:

9.1.1.1 Department of Family Practice

9.1.1.2 Department of Medicine

9.1.1.3 Department of Surgery

9.1.1.4 Department of Emergency Medicine

9.1.2 SPECIALTY SECTIONS WITHIN A DEPARTMENT

Each department may be further subdivided into specialty Sections. The Sections are:

9.1.2.1 Department of Medicine/Family Practice:

9.1.2.1.1 Section of Cardiology

9.1.2.1.2 Section of Radiology

9.1.2.1.3 Section of Neurology

9.1.2.2 Department of Surgery:

9.1.2.2.1 Section of General Surgery (to include subspecialties, which are not designated as separate sections)

9.1.2.2.2 Section of Anesthesiology

~~9.1.2.2.3 Section of Obstetrics/Gynecology~~

~~9.1.2.2.4 Section of Ophthalmology and Otorhinolaryngology, Oral Surgery and General Dentistry~~

9.1.2.2.5 Section of Orthopedics, Neurosurgery and Podiatry

~~9.1.2.2.6 Section of Pathology~~

9.1.2.2.7 Section of Cardiovascular Surgery

9.1.2.3 Department Emergency Medicine

9.1.3 Other departments or sections may be established from time to time upon the written request to the Executive Committee by the membership of the Active Staff or a department and upon approval of the Executive Committee and the Board of Trustees.

9.2 CRITERIA TO QUALIFY AS A DEPARTMENT OR SECTION

The Medical Executive Committee may create, eliminate, subdivide or combine Departments or Sections, subject to approval by the Board, based on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Department or a Section is to be responsible for the quality of patient care provided by the members of the Department or Section, the primary criteria for creating or subdividing a Department or Section, or in eliminating or combining a department or Section shall be whether the Department or Section has a sufficient number of active staff members and sufficient patient volume to support the quality assurance and performance improvement activities required of a Department or Section.

9.2.1 CRITERIA TO QUALIFY AS A DEPARTMENT

To qualify as a Department, there shall be at least ten (10) active staff members in a clinically distinct area of medical practice with sufficient patient volume to support meaningful ongoing quality assurance and performance improvement activities.

9.2.2 CRITERIA TO QUALIFY AS A SECTION

To qualify as a Section, there shall be at least three (3) active staff members in a clinically distinct area of medical practice with sufficient patient volume to support the occasional need of these specialists to deliberate quality of care issues unique to their specialty.

9.3 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS AND SECTIONS

Each Medical Staff member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A Medical Staff member or other individual with clinical privileges may be assigned to a Section if one exists related to the member's or individual's clinical specialty. A member or other individual with clinical privileges may be granted clinical privileges in one or more other departments. The exercise of clinical privileges within any department shall be subject to the rules and regulations of the Department and the authority of the Department chairperson.

9.4 FUNCTIONS OF DEPARTMENTS

The Departments shall meet at least annually to perform the following functions:

9.4.1 CLINICAL FUNCTIONS

9.4.1.1 Serve as a forum for the exchange of clinical information regarding services provided by Department members;

9.4.1.2 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;

9.4.1.3 Provide recommendations to the Department Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board that patients shall receive quality care. The recommendations shall include:

9.4.1.3.1 Criteria for granting, withdrawing and modifying clinical privileges;

9.4.1.3.2 A procedure for applying these criteria to individuals requesting privileges.

9.4.1.4 Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;

9.4.1.4.1 By establishing uniform patient care processes;

9.4.1.4.2 By establishing similar clinical privileging criteria for similar privileges;

9.4.1.4.3 By using similar indicators in performance improvement activities.

9.4.1.5 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;

9.4.1.6 Ensure effective mechanisms for the clinical supervision of Allied Health Professionals, and House Staff practitioners, if any.

9.4.2 ADMINISTRATIVE FUNCTIONS

9.4.2.1 Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the department;

9.4.2.2 Ensure that individuals within the Department who admit patients have privileges to do so, and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.

9.4.2.3 Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff policies and procedures;

9.4.2.4 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.

9.4.3 QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT ACTIVITIES

9.4.3.1 Perform peer review and quality assurance activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;

9.4.3.2 Ensure appropriate quality control is performed, if applicable to the Department;

9.4.3.3 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

9.4.4 COLLEGIAL AND EDUCATIONAL FUNCTIONS

9.4.4.1 Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.

9.5 FUNCTIONS OF SECTIONS

The Sections shall meet as often as necessary at the call of the Section Chief to perform the following functions:

9.5.1 The Section meetings shall serve as a forum to discuss clinical aspects of care related to the Section;

9.5.2 The Section may be requested by the Department Chairperson or Medical Executive Committee to meet to discuss specific issues related to quality assurance, peer review, performance improvement, and/or credentialing. In such cases, the Section shall report their findings directly to the Department Chairperson or the Medical Executive Committee.

9.6 OFFICERS OF DEPARTMENTS AND SECTIONS

9.6.1 IDENTIFICATION

The officers of the Departments and Sections shall be the Department Chairperson, the Department Vice-Chairperson, and the Section Chief.

9.6.2 QUALIFICATIONS

The officers of the Departments and Sections shall be active staff members in good standing. Each Department Chairperson and Vice-Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department. The Section Chief shall have demonstrated ability in the specialty represented by the Section. All officers of the Departments and Sections shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.

9.6.3 ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote and in attendance at the last meeting of the Department of each even numbered year. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year. The Chairperson of the Department to which the Section is affiliated shall appoint the Section Chief.

9.6.4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department and Section officers shall serve a term of office of one year. No person may serve in the same position for more than two consecutive terms.

9.6.5 RESIGNATION

Any Department or Section officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

9.6.6 REMOVAL

Any Department or Section officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

9.6.6.1 Failure to perform the duties of office;

9.6.6.2 Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

9.6.6.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

9.6.6.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,

9.6.6.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

9.6.7 RECALL

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of

the Department members eligible to vote in medical Staff-Elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. Sealed, authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

9.6.8 VACANCY

In the event of a vacancy in one of the Department officer positions, the Chief of Staff shall appoint an interim officer until an election can be held at the next Department meeting. In the event of a vacancy in a Section Chief position, the Chairperson of the Department to which the Section is affiliated shall appoint a new Section Chief.

9.6.9 RESPONSIBILITY AND AUTHORITY

9.6.9.1 Department Chairperson: Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chairperson. Each Department Chairperson shall be responsible for the following duties:

9.6.9.2 Presiding at all meetings of the Department;

9.6.9.2.1 Appointing Department members to the positions of Section Chief and to membership positions on Departmental committees, if any;

9.6.9.2.2 Serving as an ex-officio member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

9.6.9.2.3 Serving as a member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assurance and performance improvement activities of the Department to the Medical Executive Committee;

9.6.9.2.4 Conducting all clinically related activities of the Department;

9.6.9.2.5 Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;

9.6.9.2.6 Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

9.6.9.2.7 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

9.6.9.2.8 Recommending clinical privileges for each member of the Department;

9.6.9.3 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;

9.6.9.3.1 Integrating the Department into the primary functions of the Hospital;

9.6.9.3.2 Coordinating and integrating interdepartmental and intradepartmental services;

9.6.9.3.3 Developing and implementing policies and procedures that guide and support the provision of services;

9.6.9.3.4 Recommending a sufficient number of qualified and competent persons to provide care or services;

9.6.9.3.5 Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;

9.6.9.3.6 Ensuring the continuous assessment and improvement of the quality of care and services provided;

9.6.9.3.7 Maintaining quality control programs, as appropriate;

9.6.9.3.8 Ensuring the orientation and continuing education of all persons in the Department;

9.6.9.3.9 Recommending appropriate space and other resources needed by the Department.

9.6.9.4 Department Vice-Chairperson: The Vice-Chairperson shall assist the Department Chairperson in the performance of the Chairperson's duties, and shall assume the duties of the Chairperson in his/her absence.

9.6.9.5 Section Chief: The Section Chief shall be responsible for promoting quality of patient care in the Section. Each Section Chief shall be responsible for the following duties:

9.6.9.5.1 Calling and giving notice of a meeting of the Section members, to be held on an ad hoc basis, when issues are identified that require the members to deliberate quality of care issues unique to their specialty. The Section Chief shall preside at all of the meetings of the Section;

9.6.9.5.2 Being accountable to the Department Chairperson with regard to the activities and functioning of the Section, specifically to report any quality assurance and performance improvement activities of the Section at the meetings of the Department.

10 ARTICLE TEN: FUNCTIONS AND COMMITTEES

10.1 FUNCTIONS OF THE STAFF

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments, Sections, and committees that compose the Medical Staff structure.

10.1.1 GOVERNANCE

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

10.1.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board.

10.1.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.

10.1.2 PLANNING

The leaders of the Hospital include members of the Board, the CEO and other senior managers, department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders. Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

10.1.2.1 Planning patient care services;

10.1.2.2 Planning and prioritizing performance improvement activities;

10.1.2.3 Budgeting;

10.1.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff departments, across departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

10.1.2.5 Recruitment, retention, development, and continuing education of all staff;

10.1.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.

10.1.3 CREDENTIALING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

10.1.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.

10.1.3.2 Establish professional criteria for membership and for clinical privileges.

10.1.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.

10.1.3.4 Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.

10.1.3.5 Establish a mechanism for fair hearing and appellate review.

10.1.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.

10.1.4 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients. All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital's quality assurance and performance improvement activities. All organized services related to patient care shall be evaluated. The Hospital's quality assurance and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical Staff departments and Sections, the Medical Staff Quality/Peer Review Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assurance and performance improvement that are listed below. The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members.

10.1.4.1 Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital's quality assurance and performance improvement activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

10.1.4.1.1 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

10.1.4.1.2 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

10.1.4.1.3 Use of blood and blood components, including the review of any significant transfusions reactions;

10.1.4.1.4 Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;

10.1.4.1.5 Efficiency of clinical practice patterns, including the review of readmissions, appropriateness of discharge, and resource/utilization review; and,

10.1.4.1.6 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff.

10.1.4.2 Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities shall include, but are not limited to a review of the following:

10.1.4.2.1 Education of patients and families;

10.1.4.2.2 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,

10.1.4.2.3 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates.

10.1.4.2.4 Surveillance of nosocomial infections.

10.1.4.3 Medical Staff Peer Review: When the findings of quality assurance or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.

10.1.5 CONTINUING AND GRADUATE MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Company policy. The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.1.5.1 The type and nature of care offered by the hospital; and,

10.1.5.2 The findings of performance improvement activities.

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities.

10.1.6 BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

10.1.6.1 Remain consistent with the Bylaws of the Board of Trustees;

10.1.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;

10.1.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities; and,

10.1.6.4 Remain consistent with Hospital policies.

10.1.7 NOMINATING COMMITTEE

10.1.7.1 COMPOSITION

The Nominating Committee shall be composed of the Chief of Staff, the Vice Chief of Staff, and at least four (4) members of the Active Staff in good standing appointed by the Chief of Staff.

10.1.7.2 DUTIES AND AUTHORITY

The Nominating Committee shall perform the key function of Nominating, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee.

The Nominating Committee shall prepare and recommend a slate of nominees for the office of the Vice Chief of Staff and the office of the Secretary-Treasurer.

10.1.7.3 MEETINGS AND REPORTING

The Nominating Committee shall meet annually, at least thirty (30) days prior to the annual meeting (3rd Quarter Medical Staff Meeting), maintain a permanent record of its proceedings and actions, and report its recommendations to the President/CEO and Chief of Staff.

10.2 PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments, Sections, and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the Chief of Staff may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

10.3 DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Standards and Credentials Committee, the Quality/Peer Review Committees, the Bylaws Committee, the Nominating Committee, and the Medical Education/Osteopathic Methods Committee.

10.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

10.4.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of

Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation. Medical Staff representatives for a Hospital committee shall be appointed by the Chief of Staff with input from the CEO.

10.4.2 EX OFFICIO MEMBERS

The CEO and Chief of Staff shall be ex-officio members of all Medical Staff committees. The CEO may designate another senior administrative member to attend any meeting in his/her place. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

10.4.3 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Within one month prior to the end of each Medical Staff year, the Medical Executive Committee shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Quality/Peer Review Committee and any other committee performing a professional review activity shall be subject to ratification by the Board per Article Eight, Section 8.3.3 of these Bylaws. The CEO, in consultation and with the approval of the Chief of Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

All committee members are expected to attend their committee meetings, and failure to attend fifty percent (50%) of said meetings may result in the physician being dropped from the committee at the discretion of the Chief of Staff.

10.4.4 TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee member shall be one (1) year. To promote continuity, the committee membership appointments shall commence on the first day of the year.

If a chairperson or member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the Chief of Staff, the Medical Executive Committee, or the Board may remove that member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

10.4.5 NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than three (3) days before the meeting.

10.4.6 MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Departments, and Sections shall be held on the campus of the Hospital.

10.4.7 QUORUM

Twenty-five percent (25%) of the active and associate members of a department (or section thereof) or five (5) members, whichever is less, shall constitute a quorum at any meeting. Active and associate members of the department (or section thereof) are eligible to vote at departmental or section meetings.

Minutes of all committee meetings shall be taken and maintained in the office of the President/CEO. A quorum shall consist of at least one (1) committee member.

10.4.8 MANNER OF ACTING

The act of a majority of the voting members of a committee present at a meeting at which a quorum is present shall be the act of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if a consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

10.4.9 ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

10.4.10 MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for perpetuity.

10.4.11 PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

10.4.12 REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

10.4.13 COMMITTEES, DEPARTMENTS AND SECTIONS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual's qualifications and competence, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

The Chief of Staff shall, after consultation with the Executive Committee, and with the approval of the Board of Trustees, appoint members to all standing committees except the Executive Committee, unless otherwise provided in these Bylaws.

10.4.13.1 Purpose of Peer Review: The purpose of the Hospital's peer review processes, programs, and proceedings are to encourage candid discussions

in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

10.4.13.1.1 To improve the quality of health care provided to patients;

10.4.13.1.2 To reduce morbidity and mortality at the Hospital;

10.4.13.1.3 To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

10.4.13.1.4 To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

10.4.13.2 Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

10.4.13.3 Peer Review Process: A peer review process is any process, program or proceeding utilized by the Hospital to (a) assess, review, study, or evaluate the credentials, competence, professional conduct, health care services, or patient care activities of a Practitioner or other individual with clinical privileges, or (b) to assess, review, study, or evaluate the quality or efficiency of health care services provided, ordered or performed by the Hospital or any Practitioner or other individual with clinical privileges for any of the following purposes: improving the quality of care; reducing morbidity or mortality; epidemiological studies; infection control; utilization review or utilization management; accreditation, certification, or licensing; participation in the Medicare, Medicaid, or other government health benefits program; improving organizational performance, or educational purposes. A peer review process may involve the retrospective, concurrent, and prospective review or evaluation of information, patient care activities, and data.

10.4.13.4 Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: performance improvement, utilization management, credentialing, infection control, use of medications, use of blood and blood components, clinical risk management, quality assessment, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.

10.4.13.5 Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names of individuals who present or provide information during a peer review process should be documented.

10.4.13.6 Credentialing Records: The credentialing record or file of each Practitioner or other individual with clinical privileges shall be segregated so that the documents that are subject to the peer review privilege are maintained separately and identified as peer review information. Generally,

the documents that are not subject to the peer review privilege include the initial application, application for reappointment, request for privileges, and correspondence from the Practitioner or other individual with clinical privileges.

10.4.13.7 Custody: Peer review information, including Medical Staff records, shall be maintained under the custody of the Chief of Staff and the CEO.

10.4.13.7.1 A Practitioner or other individual with clinical privileges may have copies of any documents in his/her own credentials and peer review file, which he/she submitted (that is, his/her initial application, application for reappointment, request for privileges, or correspondence from him/her) or which were sent or delivered to him/her. A Practitioner or other individual with clinical privileges shall be permitted access to further information in that credentials file only if, following a written request by the individual, the Medical Executive Committee and the Board find that the individual has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.

10.4.13.8 Medical Staff Officers: Members of the Board, licensing agencies, accreditation and regulatory authorities, the CEO, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the CEO and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.

10.4.13.9 Outside Requests for Information: The Medical Staff Office and the Chief of Staff (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with clinical privileges is a member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

10.4.13.10 Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

10.4.13.11 Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the CEO (or his/her designee) and the Chief of Staff (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the CEO or Chief of Staff:

10.4.13.11.1 Specific statutory, regulatory or other appropriate authority to review the requested materials;

10.4.13.11.2 The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

10.4.13.11.3 The materials sought are the most direct and least intrusive means to accomplish the purpose;

10.4.13.11.4 Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;

10.4.13.11.5 If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.

10.4.13.12 Subpoenas: All subpoenas of Medical Staff records shall be referred to the CEO and the Chief of Staff.

10.4.13.13 Legal Counsel: Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

10.4.13.14 Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the CEO and the Chief of Staff for evaluation.

10.4.13.15 Peer Review Meetings: All peer review functions shall be performed only at meetings held on the campus of the Hospital.

10.5 MEDICAL EXECUTIVE COMMITTEE

10.5.1 COMPOSITION

The Medical Executive Committee shall be composed of thirteen (13) members, of which a majority of voting members shall be fully licensed physician members of the Medical Staff actively practicing in the Hospital. The membership shall include the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff, the Secretary/Treasurer, the chairpersons of each Medical Staff department, and CEO. The CEO shall be an ex-officio member without a vote. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty. The Chief of Staff shall serve as the chairperson of the committee.

Each year, after the election, but prior to assuming office, the Vice Chief of Staff, who will assume office on the first day of the new Medical Staff Year, will prepare a list of recommended appointments. After reasonable consultations with the president/CEO, these recommended appointments will be submitted to a Committee consisting of the current and the newly elected officers of the Medical Staff for approval. This committee's recommendation will then be forwarded to the Board of Trustees for final approval prior to the start of the new medical Staff Year.

10.5.2 DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws. and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

10.5.2.1 Providing for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board.

10.5.2.2 Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

10.5.2.3 Collaborate with other leaders of the organization in Hospital planning.

10.5.2.4 Review the qualifications, evidence of current competence, and the recommendations of a Department chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, staff category, assignment to Departments and Sections, clinical privileges, and any disciplinary actions.

10.5.2.5 Organizing the Medical Staff's quality assurance and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.

10.5.2.6 Receive and act on reports and recommendations from Medical Staff committees, departments, and assigned activity groups, specifically as related to Medical Staff quality assurance and performance improvement activities.

10.5.2.7 Make recommendations directly to the Board with regard to all of the following:

10.5.2.7.1 The Medical Staff structure;

10.5.2.7.2 The mechanism used to review credentials and to delineate individual clinical privileges;

10.5.2.7.3 Recommendations of individuals for Medical Staff membership;

10.5.2.7.4 Recommendations for delineated clinical privileges for each eligible individual;

10.5.2.7.5 The participation of the Medical Staff in organization performance improvement activities;

10.5.2.7.6 Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;

10.5.2.7.7 The mechanism by which Medical Staff membership may be terminated; and,

10.5.2.7.8 The mechanism for fair hearing procedures.

10.5.2.8 Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

10.5.3 MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least 10 times a year, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board.

10.6 STANDARDS AND CREDENTIALS COMMITTEE

10.6.1 COMPOSITION

The Credentials Committee shall be composed of members who shall be active staff members in good standing. The voting membership shall include the Chief of Staff Elect (Vice-Chief) who shall chair the committee, the Section Chief of each Department of the Medical Staff, Vice-Chief of the departments and one other active staff member from each Department. In addition to the CEO, the ex-officio members without vote shall also include the Medical Staff Office Coordinator.

10.6.2 DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

10.6.2.1 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;

10.6.2.2 Through asking recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff departments, across departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

10.6.2.3 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;

10.6.2.4 Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

10.6.1.5 To review the report and recommendations of the department chairmen regarding applicants for membership to the staff to ensure that all investigations were pursued with total objectivity, fairness and impartiality, and that the recommendations are soundly based and compatible with the established criteria, needs and objectives of the Medical Staff and the hospital.

10.6.3 MEETINGS AND REPORTING

The Credentials Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.

10.7 <u>MEDICAL CARE EVALUATION COMMITTEE (TISSUE, TUMOR AND TRANSFUSION)</u>

10.7.1 <u>COMPOSITION:</u> This committee shall consist of at least twelve (12) members appointed by the Chief of Staff and shall consist of the following classifications of members:

10.7.1.1 4 members of Department of Surgery

10.7.1.2 The hospital's pathologist

10.7.1.3 A radiologist

10.7.1.4 An anesthesiologist

10.7.1.5 3 members of Internal Medicine

10.7.1.6 3 members of Family Practice

The Chief of Staff shall designate the chairperson and the member of the staff-at-large.

10.7.2 DUTIES: The duties of the Surgical Care Evaluation Committee shall be:

10.7.2.1 To act to improve the care of patients by the review of processes relating to medical, surgical and invasive procedures, their selection (appropriateness), performance (effectiveness), and outcomes.

10.7.2.2 To review and evaluate all surgery and invasive procedures performed in the hospital on the basis of agreement or disagreement among the pre-operative, post-operative and pathological diagnoses and justification of the procedure undertaken. This review and evaluation will also include those procedures in which no tissue is removed (tissue and non-tissue cases). This committee will act as a sub-committee for the Department of Surgery and Departments of Medicine and Family Practice.

10.7.3 MEETINGS: The committee shall meet no less than six times per year, maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.8 INFECTION CONTROL COMMITTEE

10.8.1 COMPOSITION: The Committee shall consist of at least four (4) members of the Medical Staff, including a pathologist and an anesthesiologist. Representatives from Nursing Services, including O.R. and Central Sterile Supply, Housekeeping, Pharmacy, Administration, Engineering, Dietary, agency, Laboratorian and Infection Control shall attend as ex-officio members.

10.8.2 DUTIES: The Committee shall be responsible for the surveillance of inadvertent infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards and the supervision of infection and environmental sanitation control in all phases of the hospital's activities. Specifically, the Infection Control Committee's duties shall be:

10.8.2.1 To develop written standards for hospital sanitation and medical asepsis to include a definition of infection for the purpose of surveillance, as well as specific indications of the need for and the procedures to be used in isolation. Copies of the standards should be distributed and made readily available to all appropriate personnel.

10.8.2.2 To develop, evaluate and revise on a continuing basis, the procedures and techniques for meeting established sanitation and aseptic standards to include the routine evaluation of materials used in the hospital's sanitation program; namely, dietary and food handling, disposing of biological wastes, traffic control and visiting hours in all areas, sources of pollution and routine periodic culturing of autoclaves and gas sterilizers. The review of existing practices should also include procedures for the education and orientation of personnel in the practice of aseptic techniques. The evaluation may be based upon data supplied from reputable sources or upon in-use tests performed within the hospital.

10.8.2.3 To develop a practical system for reporting, evaluating and keeping records of infections among patients and personnel in order to provide an indication of the endemic situations. Such a program is important not only for the protection of the patient, but also for the protection of the Medical Staff, hospital employees and visitors.

10.8.2.4 To review periodically the use of antibiotics as they relate to patient care within the hospital.

10.8.2.5 To provide assistance in the development of the hospital's employee health program.

10.8.2.6 The President/CEO shall be responsible for:

10.8.2.6.1 Conducting studies and improving procedures relating to the non-clinical aspects of the committee's work.

10.8.2.6.2 Assisting, either directly or by delegation of responsibility, in the timely planning of the administrative details necessary for the implementation and maintenance of the work of the committee.

10.8.3 MEETINGS: The Committee shall meet bi-monthly, and more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.9. SPECIAL CARE UNITS (ICU/CCU/NICU/CVICU) COMMITTEE

10.9.1 COMPOSITION: The Committee shall consist of at least three (3) members of the Medical Staff. The Nurse Managers of the Special Care Units and PCU, representatives of Respiratory Therapy, Infection Control and Staff Education, Special Care Units staff members, the Vice President/Chief Nursing Officer and a representative of Administration shall attend as ex-officio members

10.9.2 DUTIES: The duties of the Committee shall be:

10.9.2.1 To assure that the best patient care is rendered; that adequate staffing, equipment requirements and safety standards are maintained; and that training and education of nursing staff and practitioners is maintained on a continuing basis.

10.9.2.2 To seek ways and means for improving the professional standards and functions of these services for better patient care and proficiency in the execution of the detailed responsibilities.

10.9.2.3 To be responsible for formulating and assuring compliance with the established rules and regulations of the Special Care Units and for the maintenance of the highest professional conduct of the Medical Staff using these facilities.

10.9.2.4 To receive and consider all recommendations made in writing by members of the Medical Staff for the improvement of the efficiency of these units.

10.9.3 MEETINGS: The Committee shall meet at least annually, and more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff

10.10 RADIATION SAFETY COMMITTEE

10.10.1 COMPOSITION: The Committee shall consist of one (1) Radiologist, experienced in the safe handling of radioisotopes, in the measurement of radio-activity and in determining radioisotope dosage for various

patients' studies or treatments, one (1) authorized user on the hospital's Radioactive Materials License in the specialty of Cardiology or Therapeutic Radiology, one (1) representative from Administration, one (1) representative from Nursing Administration, one (1) Director of Radiology and one (1) Supervisor of Nuclear Medicine.

10.10.2 DUTIES: The duties of the Radiation Safety Committee shall be:

10.10.2.1 To review all proposals for diagnostic and therapeutic use of radionuclides

10.10.2.2 To recommend to the Medical Staff practitioners who have suitable training and experience to perform nuclear medicine procedures.

10.10.2.3 To develop regulations as to the use, removal, handling and storage of radioactive materials used in nuclear medicine procedures.

10.10.2.4 To recommend remedial action when there is failure to observe protection recommendations, rules and regulations.

10.10.3 MEETINGS: The Committee shall meet at least semi-annually and more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.11 INFORMATION & RESOURCE MANAGEMENT COMMITTEE

10.11.1 COMPOSITION: The Information and Resource Management Committee shall consist of at least (8) practitioners who are members of the Medical Staff and who broadly represent the services of the Medical Staff. The Chief of Staff shall appoint a Chairperson. The Vice President of Patient Care Services/Chief Nursing Officer or his/her designee, the Director of Pharmacy or his/her designee, the Director of Health Information Services, the Director of Resource Management, the Director of Quality Management and/or Quality Improvement Coordinator, the Infection Control Nurse and a representative of Administration shall attend as ex-officio members.

10.11.2 DUTIES: The duties of the Information and Resource Management Committee shall be:

10.11.2.1 To assure the development, maintenance and execution of a Utilization Review Plan which conforms to the requirement set forth by the Joint Commission on Accreditation of Healthcare Organizations, the requirements of Medicare/Medicaid, and other third-party payers, and to applicable State Laws.

10.11.2.2 To establish standards that assure all Medical Records meet the highest standards of patient care usefulness, historical validity, and realistic documentation of medical events. To ensure that all Medical Records conform to the requirements set forth by the Joint Commission on Accreditation of Healthcare Organizations and applicable State Laws.

10.11.3 MEETINGS: The Information and Resource Management Committee shall meet at least 10 times a year and maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.12 ETHICS COMMITTEE

10.12.1 COMPOSITION: The Ethics Committee shall consist of at least four (4) members of the Active Medical Staff, the Chairperson to be appointed by the Chief of Staff, at least one (1) member from Administration, at least one (1) member from Nursing, (from a critical care area), a layperson, a member of the clergy, and the Hospital Risk Manager.

10.12.2 DUTIES: The duties of the Ethics Committee shall be:

10.12.2.1 To provide information and assistance to physicians making ethical decisions for terminally ill patients.

10.12.2.2 To facilitate a consensus of opinion between parties regarding specific cases (conflict resolution).

10.12.2.3 To provide a forum for dialogue, discussion and debate on specific cases where clinical decisions create an ethical dilemma.

10.12.2.4 To advise on policy regarding patient consent and refusal.

10.12.2.5 To formulate and recommend policies concerning medical ethical considerations such as: use of life support systems, do not resuscitate orders, admission to intensive care unit, and care to terminally ill patients.

10.12.2.6 To periodically review legislation and relevant legal proceedings in an effort to keep hospital policies current regarding medical-ethical issues.

10.12.2.7 To provide a committee approach to decision making in dealing with ethical situations.

10.12.2.8 To evaluate specific cases which may be referred, to include but not limited to the following:

10.12.2.8.1 To review decisions made by patients and their families that might be considered questionable or unreasonable by their attending physician.

10.12.2.8.2 To review decisions made on behalf of competent and incompetent terminally ill patients when the attending physician requests a committee opinion.

10.12.3 MEETINGS: The committee shall meet, at a minimum once a year, ~~quarterly,~~ and more frequently if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.13 PHARMACY AND THERAPEUTICS COMMITTEE

10.13.1 COMPOSITION: The Pharmacy and Therapeutics Committee shall consist of at least three (3) members of the Medical Staff, one of whom shall be appointed Chairperson by the Chief of Staff. A representative of the Pharmacy, a representative of Nursing Administration, a representative of Administration and the Infection Control Nurse shall attend as ex-officio members.

10.13.2 DUTIES: The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to insure optimum clinical results and a minimum potential hazard. Specifically, the committee's duties shall be:

10.13.2.1 To assist in the formulation of broad professional policies regarding the evaluation, selection, procurement, distribution, use, safety procedures, evaluation of reported drug reactions and other matters relating to drugs in the hospital.

10.13.2.2 To serve as an advisory group to the Medical Staff and Administration on matters pertaining to the choice of drugs.

10.13.2.3 To add to and delete from the list of drugs accepted for use in the hospital.

10.13.2.4 To prevent unnecessary duplication in the stock of the same basic drug and its preparation.

10.13.2.5 To make recommendations concerning drugs to be stocked in the nursing units and by other services.

10.13.2.6 To review, revise and adopt medical staff bylaws or rules and regulations for preventing, monitoring and reporting medication errors.

10.13.2.7 To assist in the formulation of broad professional policies regarding the evaluation, selection, procurement, distribution, use, safety procedures, evaluation of reported drug reactions and other matters relating to drugs in the hospital.

10.13.2.8 To serve as an advisory group to the Medical Staff and Administration on matters pertaining to the choice of drugs. To include evaluation of clinical data concerning new drugs or preparations requested for use in the hospital.

10.13.2.9 To develop and maintain a Hospital Formulary or drug list of accepted drugs for use in the hospital and make recommendations concerning drugs to be stocked in the nursing units and by other services to prevent unnecessary duplication in the stock of the same basic drug and its preparation.

10.13.2.10 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

10.13.3 MEETINGS: The committee shall meet quarterly, and more frequently if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of the Medical Staff.

10.14. POST-GRADUATE MEDICAL EDUCATION COMMITTEE

10.14.1 COMPOSITION: The Committee shall include the Director of Medical Education, representatives from each specialty representing the requirements of rotations to be completed by interns and residents, as well as all program directors, trainers and administration. The Chairperson and members will be appointed by the Chief of Staff after consultation with the President/CEO. The Director of Medical Education is an ex-officio member of the committee.

10.14.2 DUTIES: The functions of the committee shall be as follows:

10.14.2.1 To work to maintain and improve program quality by recommending to the Director of Medical Education various developments and changes within the overall program for training Interns/Residents.

10.14.2.2 To assist the Director of Medical Education in formulating the hours of duty for the Interns/Residents.

10.14.2.3 In the event disciplinary actions occur during the Intern/Resident year, to make recommendations to the Director of Medical Education regarding such disciplinary actions.

10.14.2.4 To develop and implement a high-quality educational program for Interns/Residents.

10.14.2.5 To develop a curriculum and methods of evaluation of the educational experience of the Interns/ Residents during training.

10.14.2.6 To participate in evaluation of Interns/Residents.

10.14.2.7 Must communicate periodically with the Medical Executive Committee and the Governing Board about the performance of its residents and Interns, patient care and must work with the MEC to ensure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

10.14.2.8 To assist the Medical Librarian, or any other designated individual in charge of the professional library, to establish rules and regulations for the use of the library.

10.14.3 MEETINGS: This Committee shall meet at least monthly or more often, at the discretion of the Chairperson, and submit reports to the Executive Committee.

10.15 10.15 UTILIZATION OF OSTEOPATHIC METHODS COMMITTEE

10.15.1 COMPOSITION: The Medical Education Committee shall be composed of three (3) Osteopathic Physician voting members who shall be active staff members in good standing. The Director of Medical Education will also sit on this committee as well as representatives from the Intern/Resident. Members and chairpersons will be appointed by the Chief of Staff after consultation with the President/CEO.

10.15.2 DUTIES AND AUTHORITY: The Committee shall perform the following specific duties:

10.15.2.1 Recommendations to improve utilization of osteopathic principles and practice, to record osteopathic findings, describe osteopathic manipulative treatment and to apply such modalities as part of the comprehensive care received by patients.

10.15.2.2 Establishing and recording retrospective and current audits of patient charts relating tot eh application of osteopathic principles and practice to patient diagnosis and treatment.

10.15.2.3 Informing osteopathic physicians of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.

10.15.3 MEETINGS AND REPORTING: The Utilization of Osteopathic Methods is a sub-committee of the Medical Executive Committee and shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.

10.16 ENDOVASCULAR COMMITTEE

10.16.1 COMPOSITION: The committee shall consist of (3) radiologists, (3) vascular surgeons, (3) interventional cardiologists, (1) representative from Administration, (1) quality representative and a recorder.

10.16.2 DUTIES: The duties of the Endovascular Committee are:

10.16.2.1 To review all policies and procedures in relation to Endovascular (Non-coronary) stent placement.

10.16.2.2 To develop/adopt guidelines for the use of Endovascular (Non-coronary) stents, i.e. indications, procedural management and safety standards.

10.16.2.3 To assist in education planning for the nursing staff and medical practitioners regarding Endovascular stent placement.

10.16.2.4 To review and evaluate all Endovascular (Non-coronary) stent procedures performed on the basis of agreement or disagreement of pre-procedural and post-procedural diagnosis, justification of the procedure undertaken and patient care.

10.16.2.5 To develop operational policies for the Endovascular Lab.

10.16.3 MEETINGS: The Endovascular Committee shall meet at least quarterly a year; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Executive Committee of Medical Staff.

10.17 SPECIAL COMMITTEES

Special committees shall be appointed from time to time as may be required to carry out the duties and functions of the Medical Staff properly. These committees shall report to the Medical Executive Committee, with the exception of the Credentials Subcommittee, which shall report to the Credentials Committee, and they shall have no power to act unless specifically granted by the Medical Executive Committee.

10.18 BYLAWS COMMITTEE

10.18.1 COMPOSITION

The Bylaws Committee shall be composed of at least five (5) voting members who shall be active staff members in good standing, appointed by the Chief of Staff, one of which shall be appointed chairperson. The CEO, the ex-officio members without vote shall also include the Medical Staff Office Coordinator.

10.18.2 DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and recommend any needed additions, revisions, modifications, amendments or deletions to the Medical Executive Committee.

10.18.3 MEETINGS AND REPORTING

The Bylaws Committee shall meet at least annually, or as requested by the Executive Committee and shall report their recommendations and activities to the Medical Executive Committee.

11 ARTICLE ELEVEN: MEETINGS

11.1 MEDICAL STAFF YEAR

The Medical Staff year shall be the period from January 1 to December 31 of each year.

11.2 MEDICAL STAFF MEETINGS

11.2.1 REGULAR MEETINGS

The regular meeting of the Medical Staff shall be held annually or more frequently as needed at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

11.2.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the Chief of Staff and shall be called by the Chief of Staff at the request of the Medical Executive Committee or any ten members of the active staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.3 DEPARTMENT AND SECTION MEETINGS

11.3.1 REGULAR MEETINGS

Regular meetings of each Department shall be held at least annually or more frequently as needed to perform the functions of Departments as specified in Article Nine of these Bylaws. The Sections shall meet as often as necessary to perform Section functions.

11.3.2 SPECIAL MEETINGS

Special meetings of a Department may be called at the direction of the Chairperson of the Department and shall be called by the Chairperson or any three members of the active staff of the Department by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.4 ATTENDANCE REQUIREMENT - SPECIAL APPEARANCES

A Medical Staff member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

11.5 MEETING PROCEDURES

11.5.1 NOTICE OF MEETINGS

Notice of the date, time and place of the yearly Medical Staff meeting shall be given not less than seven (7) days or more than thirty-one (31) days prior to a regular meeting, and not less than three (3) days prior to a special meeting of the general Medical Staff by written notice delivered via fax, e-mail or Meditech to each member of the active staff at his/her address as shown in Medical Staff records. The Medical Executive Committee or the Chief of Staff may send notice to members of other categories of the Medical Staff, the CEO, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

11.6 QUORUM

11.6.1 GENERAL STAFF MEETINGS

At least 10% of the non-provisional active staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.6.2 DEPARTMENT OR SECTION MEETINGS

Ten (10 or ten percent (10%) of the non-provisional active staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff Department or Section meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.7 MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of

voting Department members present at a Medical Staff Department meeting at which a quorum is present shall be the act of the Department.

11.8 VOTING RIGHTS

Only non-provisional status active staff members have the right to vote. A non-physician member of the Medical Staff may vote on credentialing matters (such as procedures for appointment, reappointment, granting clinical privileges and discipline) only when such matters involve practitioners who hold the same professional license as the non-physician.

11.9 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

11.10 MINUTES

The Secretary/Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary/Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department Chairperson and each Section Chief shall ensure that minutes are prepared for their respective Department or Section meetings.

11.11 PROCEDURAL RULES

The Chief of Staff, or in his/her absence, the Chief of Staff-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert's Rules of Order, as may be modified by the Medical Staff.

12 ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASE

12.1 AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

12.2 CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the CEO, Administrative officials, Board members and their representatives and to third parties, who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

12.3 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assurance/performance improvement activities must be based on free and candid discussions, any breach of

confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, department, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies. Any individual, committee or entity, which may be damaged by such violation, may seek enforcement by a court order for injunctive or other appropriate relief.

12.4 IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

12.4.1 Applications for appointment to the Medical Staff or for clinical privileges;

12.4.1.1 Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;

12.4.1.2 Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;

12.4.1.3 Hearing and appellate review;

12.4.1.4 Medical care evaluations;

12.4.1.5 Peer review evaluations;

12.4.1.6 Utilization review and resource management; and,

12.4.2 Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5 RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

12.6 SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

12.7 NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

13 ARTICLE THIRTEEN: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Notwithstanding anything to the contrary contained herein, the Board shall maintain responsibility and authority over the operation of the Medical Staff and in the event the Medical Staff refuses to amend their Bylaws or Rules and Regulations to comply with local, state or federal laws and regulations or applicable accreditation standards, the Board retains the authority to unilaterally amend the Medical Staff Bylaws and Rules and Regulations to so comply.

13.2 EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

13.3 METHODOLOGY

13.3.1 MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition, submitted to the Medical Executive Committee, signed by 15 of the members of the Active Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken at a regular or special meeting of the Medical Staff, provided that written notice of the proposed amendment/repeal/adoption was sent to all members of the active staff no less than twenty (20) days prior to the meeting at which the Bylaws amendment/repeal/adoption are to be voted upon. The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed amendment/repeal/adoption. All proposed amendment/repeal/adoption once presented and approved at General Medical Staff shall be taken to MEC for their review and forwarded to the Board of Trustees. If a quorum is present as described in Article Eleven, Section 11.6.1, for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than fifty percent (50%) of the Active Staff members voting in person. Bylaws shall become effective following approval by the Board of Trustees, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text.

13.3.2 RULES AND REGULATIONS

13.3.2.1 Medical Staff Rules and Regulations: Subject to approval by the Board, the Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement these Bylaws. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges.

13.3.2.2 Department Rules and Regulations: Subject to the approval of the Medical Executive Committee and the Board, each department shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws and the Rules and Regulations of the Staff or other policies of the Hospital.

13.4 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations.

13.5 GENERAL PROVISIONS

13.5.1 SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws, which will govern the combined medical staffs, subject to the approval of the hospital's Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

13.5.2 AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

13.5.3 NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

13.5.4 NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

13.5.5 NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges, which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

13.5.6 CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself/herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

13.5.7 NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent

agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.8 CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

13.5.9 ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

15. CERTIFICATION OF ADOPTION AND APPROVAL

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NO CHANGES

Reviewed and Approved and Adopted by the Medical Staff of Northside Hospital & Heart Institute on

June 18, 2018.

Chief of Staff

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Approved and Adopted by the Board of Northside Hospital & Heart Institute on

March 26, 2018.

Chairperson of the Board