PALMS OF PASADENA HOSPITAL
MEDICAL STAFF BYLAWS

PREAMBLE

Recognizing that the medical staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital governing body, and that the best interests of the patient are better protected by concerted effort, the practitioners of this hospital are hereby organized in conformity with these bylaws, rules and regulations.

DEFINITIONS

1. Administrator: The individual appointed by the hospital ownership corporation to act ~~in~~ on its behalf in the overall management of the hospital.

2. Allied Health Professional (AHP): Licensed individuals, including ARNPs and Physician Assistants (but not those defined below under "Licensed Independent Practitioner") who provide defined direct patient care services in the hospital under the supervision of a physician who is a member of the active, courtesy or consulting Medical Staff, exercising clinical judgment within the areas of their documented professional competence and consistent with their clinical privileges granted through the Medical Staff credentialing processes, and applicable law.

3. 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.

4. Clinical Privileges: Specified diagnostic and therapeutic practice areas that may be exercised by authorized individuals on approval of the governing body, based on the individual's professional license and documented competence, experience, and judgment.

5. Collegial: Characterized by equal power and authority among peers.

6. Dentist: An individual who has received a doctor of dental surgery or a doctor of dental medicine degree and is currently fully licensed to practice dentistry.

7. Department: A clinical division of the medical staff, grouping members in accordance with their specialty or major practice interest, as specified in Article X of these Bylaws.

8. Department or Service Chief: The member of the active medical staff who is duly selected in accordance with these bylaws to serve as the head or director of a clinical department or service.

9. Medical Executive Committee: The executive committee of the medical staff, unless otherwise specified.

10. 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.

11. Gender: "He/his/him" is applicable to either male or female in the context of these bylaws, rules and regulations.

12. Governing Body: The local Board of Trustees of the hospital, appointed by the Board of Directors of the hospital ownership corporation.

13. Hospital-Based Physician: (1) A physician whose specialty is one of the following: Anesthesiology, Diagnostic Radiology, Emergency Services, Pathology, Therapeutic Radiology or inpatient Acute Rehab, or (2) a physician who works solely as a Hospitalist, who does not have an office-based medical practice. This definition does not cover those Medical Staff members who temporarily provide coverage for a Hospitalist.

14. Licensed Independent Practitioner (LIP): Those healthcare practitioners, including dentists, oromaxillofacial surgeons and PhD. Psychologists, duly licensed in the State to practice independently within the scope of their licensure.

15. Medical Staff: The formal organization of all physicians (M.D., D.O., MSSB or MBChB) holding unlimited licenses in this state, and all podiatrists duly licensed in this state who are privileged to provide patient care services in the hospital within the scope of their licensure and approved clinical privileges. This may be referred to as "staff" where the meaning is clear.

16. Medical Staff Term: The period from July 1 to June 30.

17. Medico-Administrative Officer: A practitioner, usually a physician, who is employed by or otherwise engaged by the hospital on a full-time or part-time basis, whose responsibilities may be both administrative and 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.

18. Member: A practitioner who has been granted medical staff membership with or without clinical privileges pursuant to these bylaws.

19. Office-Based Medical Practice: An office-based medical practice is defined as a practice where the physician maintains a medical office in which he regularly attends and treats patients. As later defined in these bylaws, all medical staff members, with the exception of hospital-based physicians, must maintain an office-based medical practice; physicians who enjoy only surgical assisting privileges are excluded from this requirement. Physicians who provide temporary coverage for a Hospitalist may maintain their office-based medical practice.

20. Organized Medical Staff: For purposes of these bylaws, the organized medical staff is the Active Medical Staff.

21. Organized Health Care Arrangement shall mean a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider.

22. Patient Safety Organization (PSO): A private or public entity, or component thereof that is listed as a PSO by the Department of Health and Human Services. The primary purpose of a PSO is to collect, aggregate and analyze confidential information reported to it by health care providers to identify patterns of failures (in patient safety and quality of care) and propose measures to eliminate patient safety risks and hazards.

23. Patient Safety Evaluation System: Means the collection, management or analysis of information for report to or by a PSO.

24. Patient Safety Work Product:

(1) Except as otherwise provided by law, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statement (or copies of any of this material):

(i) Which could improve patient safety, health care quality, or health care outcomes; and

A. Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or

B. Are developed by a PSO for the conduct of patient safety activities; or

(ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

26. Physician: An individual who has received a doctor of medicine or doctor of osteopathy degree and is currently fully licensed to practice medicine.

27. Podiatrist: An individual who has received a doctor of podiatric medicine degree and is fully licensed to practice podiatry.

28. Practitioner: A physician with a current unlimited license duly issued by the State of Florida, or a podiatrist, who is duly licensed by the State of Florida.

29. Service: A subdivision of either the medical staff or a clinical department, grouping members in accordance with their specialty or major practice interest, as specified in Article X of these bylaws.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Palms of Pasadena Hospital.

ARTICLE II
PURPOSES AND RESPONSIBILITIES

SECTION 1 - PURPOSES

The purposes of the medical staff are to:

A. Provide one organized collegial body through which the benefit of staff membership (mutual education, consultation, and professional support) may be obtained by each staff member and the obligations of staff membership may be fulfilled;

B. Serve as the primary means for accountability to the governing body for the quality and appropriateness of the professional performance and ethical conduct of its members as well as of all designated professional personnel; and to strive to provide patient care of professionally recognized quality which is efficiently delivered, and is maintained consistent with available resources, and, to the degree reasonably possible, achievable by the state of the healing arts;

C. Develop an organizational structure, reflected in medical staff bylaws, rules and regulations, policies and procedures, protocols, etc., that adequately defines the responsibility and, when appropriate, the authority and accountability of each organizational component; and

D. Provide a means through which the medical staff may participate in the hospital's policy-making and planning process.

SECTION 2 - RESPONSIBILITIES

The responsibilities of the medical staff are to account for the quality and appropriateness of patient care rendered by all practitioners and designated professional personnel authorized to provide patient care services in the hospital, through the following measures:

A. Processing credentials in a manner that matches verified qualifications, performance, and competence with clinical privileges for all medical staff applicants and members, and for all designated professional personnel;

B. Making recommendations to the governing body with respect to medical staff appointments, reappointments, staff category, professional status, clinical privilege delineation, and, as appropriate, department or service assignment and corrective action;

C. Participating in the hospital quality assurance program by conducting objectively all required peer evaluation activities through medical staff and/or department/service review, specific (committee) monitoring processes, and a comprehensive occurrence screening program;

D. Providing an effective utilization review program for allocation of medical/health services based upon patient-specific determinations of individual medical needs.

E. Providing continuing education that is relevant to patient care provided in the hospital as determined, to the degree reasonably possible, from the findings of quality-related activities;

F. To comply with the Hospital's Privacy policies and procedures regarding the confidentiality of healthcare information, Patient Safety Work Product, and information included in the Patient Safety Organization (PSO), and to participate as part of an organized healthcare arrangement for purposes of the Notice of Privacy Practices provided to patients of the Hospital, and maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board of Trustees or required by laws including but not limited to information included in the Patient Safety Organization (PSO); Patient Safety Evaluation System (PSE); and Patient Safety Work Product (PSWP).

G. Providing leadership in activities related to patient safety, including oversight in the process of analyzing and improving patient satisfaction;

H. Initiating and pursuing corrective action when indicated; and

I. Enforcing the medical staff bylaws, rules and regulations uniformly and consistently.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

SECTION 1 - MEMBERSHIP AS A PRIVILEGE

Membership on the medical staff of Palms of Pasadena Hospital is a privilege that shall be extended only to professionally qualified and competent Physicians and Podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws, rules and regulations and the bylaws and policies of the hospital. Appointment to and subsequent membership on the medical staff shall confer on the appointee or member only such clinical privileges and such rights as have been granted by the governing body in accordance with these bylaws.

Licensed Independent Practitioners are important members of the Hospital's professional staff who may exercise those clinical privileges as provided by their credentialing through the Medical Staff credentialing process without direct supervision of a physician. Although they are not Medical Staff members and have no vote and cannot hold office or admit patients, they are encouraged to attend the meetings of that Medical Staff Department and any committee to which they are assigned, as well as educational conferences, and are bound by the appropriate provisions of these Medical Staff Bylaws, Rules and Regulations.

Allied Health Professionals are also important members of the Hospital's professional staff who are accountable at all times to a member of the Medical Staff and shall be under that Physician's supervision and direction, and may exercise those limited clinical privileges as provided by their credentialing through the Medical Staff credentialing processes. They are encouraged to attend Medical Staff educational sessions and conferences, and may attend Medical Staff, Department and Committee meetings if invited by those groups. They may not be members of the Medical Staff, shall not admit patients nor vote or hold any Medical Staff office.

SECTION 2 - GENERAL CRITERIA FOR MEMBERSHIP

Medical staff membership and/or clinical privileges shall not be denied on the basis of sex, race, creed, color, national origin, or, subject to the following exceptions, on the basis of any other criterion unrelated to the delivery of quality patient care in the hospital, but shall be related to professional ability and judgment; to health status; to the hospital's purposes, needs, and non-exclusive capabilities. When the determination is based on the hospital's needs or its non-exclusive ability to provide the facilities, beds, and support staffing/services, consideration will be given to utilization patterns, present and projected patient mix, and actual and planned allocations of physical, financial, and human resources; to general and specialized clinical and support services; and to the hospital's specific goals and objectives as reflected in the hospital's short and long range plans. It is recognized that some patient care services at the hospital may be provided exclusively by a limited number of practitioners selected by the hospital, and who have been properly processed and granted medical staff membership and/or clinical privileges.

SECTION 3 - QUALIFICATIONS FOR MEMBERSHIP

A. Only physicians and podiatrists currently licensed to practice in the State of Florida and who have completed an approved Residency Program, except as noted below, and are eligible to apply for their certification examination or are Board certified in their specialty of practice by a certifying board approved by the American Board of Medical Specialties or a comparable board, to include the American Board of Podiatric Surgery and the American Osteopathic boards, who can document their background, professional experience, education, training, and demonstrated competence; their adherence to the ethics of their profession; their good reputation; and their ability to work with others (staff members, members of other health care disciplines, hospital management and employees, visitors, patients, and the community in general); with sufficient adequacy to demonstrate to the medical staff and governing body that any patient treated by them in the hospital or in any of its facilities will be given quality medical care, shall be qualified for membership on the medical staff.

Core E.R. physicians must have completed an Emergency Medicine residency program and be either Board Eligible or Board Certified by the ABEM or AOBEM. Those who are Board Eligible are also required to achieve Board Certification within three years of their initial Medical Staff appointment.

Fast Track Emergency Room Physicians (1) must demonstrate evidence of successful completion of an approved ACGME or AOA residency program in either Emergency Services, Family Practice, Internal Medicine or General Surgery, and (2) must be Board certified or an Active Candidate for certification by either the American Board of Emergency Medicine, the American Board of Family Practice, the American Board of Internal Medicine, the American Board of Surgery, or an equivalent AOA certifying Board.

New practitioners on Staff who are not yet Board certified must become Board certified in their primary specialty within a three-year period of their initial appointment to the Medical Staff to retain Staff membership. Compliance with this requirement will be verified at the practitioner's next reappointment date following this three-year period. Those practitioners who fail to achieve Board Certification may not reapply for Medical Staff membership/privileges until they have successfully obtained Board Certification in their primary specialty. Those members of the Medical Staff of Palms of Pasadena Hospital who are not Board certified or Board eligible as of 4.2.96 are exempt from compliance with the above requirement for the continuation of their Medical Staff membership. New practitioners joining the Medical Staff after 7.1.09 are required to maintain continuous board certification in their primary specialty to retain Medical Staff membership, except for Honorary Staff members. Practitioners on Staff prior to 7.1.09 are encouraged to maintain continuous board certification in their primary specialty; however, it is not a requirement for renewal of membership/privileges.

The fact that an applicant possesses a current valid unrestricted professional license from the State of Florida will serve as evidence that he has met the continuing medical education requirements for Medical Staff appointment and reappointment. Evidence of a minimum of eight (8) hours of continuing medical education in the practitioner’s primary specialty is required at time of reappointment.

B. No individual is automatically entitled to initial or continued membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely because he is duly licensed to practice in this or any other state; because he has previously been a member of this medical staff; or because he had, or now has, staff membership or privileges at another health care facility or in another practice setting; or because he is a member of any professional organization. Medical Staff will be aware of and comply with PSO rules and regulations.

C. All applicants for staff membership and/or clinical privileges must be free of or have under adequate control any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required in Section 3A above, such that patient care is or is likely to be adversely affected.

D. Each applicant for staff membership, with the exception of Honorary Staff members, by applying for or being granted staff membership or temporary privileges, thereby obligates himself to:

1. Adhere to generally recognized standards of professional ethics of his profession;

2. Not participate in fee splitting or "ghost" surgical or medical care;

3. Participate, as required, in peer evaluation activities;

4. Provide continuous care for his patients and delegate the responsibility for diagnosis or care of patients only to a practitioner on the Medical Staff who is qualified to undertake that responsibility. At the determination of the Medical Executive Committee (MEC), this requirement for coverage may be temporarily waived for a critical needs physician specialist. Any temporary waiving of this requirement shall be reviewed at time of the physician's reappointment by the MEC;

5. Obtain appropriate informed consent as required for the intervention contemplated;

6. Abide by the medical staff bylaws, rules and regulations, Local, Federal and State of Florida Law, The Joint Commission provisions and hospital policies affecting the medical staff;

7. Complete adequately, and in a timely fashion, the medical and any other required records for all patients he admits or in any way provides care for in the hospital;

8. Seek consultation whenever necessary;

9. Maintain financial responsibility for professional liability, as meets the requirements of Florida law. Coverage shall be appropriate to the practitioner's clinical privileges and licensure. Florida's financial responsibility law may be satisfied in one of the following manners:

   - Obtaining professional liability coverage in conformity with s.458.320(2)(b) and s.459.0085(2)(b), Florida Statutes, in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. If the policy is a claims-made policy, then it must have at least a two-year retroactivity period.

   - Establishing an escrow account in conformity with s.458.320(2)(a) and s.459.0085(2)(a), Florida Statutes, in the amount of $250,000 per claim and $750,000 in the aggregate, consisting of cash or cash equivalents, as enumerated by s.625.52, Florida Statutes.

   - Establishing an irrevocable and nonassignable letter of credit in conformity with Chapter 675 and s.458.320(2)(c) and s.459.0085(2)(c), Florida Statutes, with an authorized bank or savings association in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000.

10. Reasonably assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his professional competence and credentials.

11. Reasonably cooperate with the hospital in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements, including Medicare/PRO requirements.

E. The applicant must be willing to appear for interviews with regard to his application, if requested.

SECTION 4 - APPOINTMENTS AND REAPPOINTMENTS.

A. Initial appointments and reappointments to the medical staff shall be made by the governing body upon a recommendation from the medical staff, and shall be for a period of two (2) years. However, in the event of unusual delay for initial appointments (defined as a maximum of 100 days after the receipt of the fully completed application) by, or inappropriate recommendation on the part of, the medical staff, the governing body may act without or contrary to such recommendation on the basis of documented evidence of the applicant's or member's professional and ethical qualifications, obtained from reliable sources other than the medical staff. Prior to taking such action, however, the governing body should notify the medical staff of its intent and should designate an action date prior to which the medical staff may still fulfill its responsibility. Peer input, from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice, shall be obtained and considered for all applications for appointment and reappointment.

B. All initial appointments to the medical staff for active or courtesy categories shall be provisional for twelve (12) months. Individual provisional case review requirements are outlined in each appropriate Clinical Department Rules and Regulations. At the end of the provisional period or any extension thereof, the appointee must be (1) advanced to regular (non-provisional) status; or (2) extended on provisional status for a period not to exceed an additional twelve- (12) month period, at the end of which time he will be re-evaluated; or (3) dropped from the staff with written notification and any entitlement to procedural rights as specified by these bylaws. No member may have his provisional status extended for a period longer than a cumulative period of twelve (12) months, with the total provisional period not to exceed twenty-four (24) months. Provisional members of the Active and Courtesy Medical Staffs shall be evaluated, on an annual basis, until such time as their provisional periods have been deemed complete. Any of the above actions must be indicated in writing in the individual's credentials file.

SECTION 5 - PROCEDURE FOR APPOINTMENT

A. Application for Initial Appointment or Clinical Privileges. Each application for appointment to the staff and/or for clinical privileges, shall be in writing, submitted as a "Request for Consideration", which will be sent to HCA's Credentialing Processing Center (CPC) for evaluation. When an applicant requests an application, he shall also be given a copy of these bylaws, rules and regulations and any designated current hospital policies that relate to his activities as a member of the medical staff or a holder of clinical privileges.

B. Applicant's Responsibility, Application Form and Content. The applicant shall provide up-to-date information, and shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, health status and other qualifications; the application form shall include but not be limited to, the following:

1. Identifying information;

2. Undergraduate education;

3. Postgraduate education;

4. Internship;

5. Residency/fellowship;

6. All past and present hospital/other healthcare affiliations, including voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, loss or denial of clinical privileges at other hospitals;

7. Membership in professional associations, societies, academies, colleges, and faculty/training appointments;

8. Specialty board certification status;

9. State licensure(s), with expiration date, including successful or currently pending challenges to or voluntary/involuntary relinquishments of state licensure(s);

10. DEA registration, with expiration date, including successful or currently pending challenges to or voluntary/involuntary relinquishments to DEA registration;

11. Professional references;

12. Previous practice data;

13. Continuing medical education for the past two years;

14. Bibliography of publications, speeches, and meetings attended, with dates;

15. Financial responsibility for professional liability, as meets the requirements of Florida law, including professional litigation and liability history (past and present), to include final judgments or settlements and pending claims;

16. Multiple questions regarding sanctions, health status, etc.;

17. A request for staff category and, if such exists, the department or clinical service assignment desired;

18. Clinical privileges desired;

19. A specific signed consent for immunity and release from liability for all individuals involved in and performing the credentials function;

20. A list of cases treated or procedures performed may be required;

21. A small photo. (Note: An application shall not be denied nor deemed incomplete due to failure to provide the requested photo.)

22. A non-refundable application fee as may be established from time to time by recommendation of the MEC and approval of the Board of Trustees. The application fee shall be deposited in the Palms of Pasadena Hospital Medical Staff Library Fund.

C. The applicant shall further be responsible for resolving any doubts as to any of the matters indicated in subparagraph B-16 above. If any information supplied by the applicant contains significant misrepresentations or omissions or fails to sustain his required responsibility to produce

adequate information, this may be grounds for denial of his application. The applicant shall immediately report to the administrator any change in such information occurring after the application has been submitted.

D. When the CPC returns the completed "Request for Consideration", it shall be submitted to the Medical Staff Office who shall assist the Standards and Credentials Committee in having all information verified for purposes of evaluation. An application shall be deemed complete when the Medical Staff Office and CPC has received all requested supporting documentation from primary sources, whenever possible, which appropriately verifies all information on the submitted application, to include but not necessarily be limited to evidence of (1) current FL licensure, (2) relevant training and experience, (3) current competence, (4) ability to perform requested privileges, (5) no current or previously successful challenges to licensure or registration, (6) no subjection to involuntary termination or medical staff membership at another organization, (7) no subjection to involuntary limitation, reduction, denial or loss of clinical privileges and (8) a query and evaluation of the National Practitioner Data Bank information. The Credentials Committee may request further reasonable documentation or clarification.

If an application cannot be deemed complete within four (4) months from its receipt in the Medical Staff Office, the applicant will promptly be notified by Standards and Credentials Committee that his application cannot be acted upon without the required documentation, and he will be given an additional 60 days to complete the application requirements. Failure to do so will cause the processing of the application to be discontinued. If the requested supporting documents have not been supplied by the applicant or the application is not otherwise complete, or if requested further documentation or clarification is not submitted, the applicant will be notified promptly by the credentials committee and given 60 days to complete the application requirements. Failure to do so will cause the processing of the application to be discontinued and the applicant will be so notified. Notwithstanding any other provision of these bylaws, any individual whose application has been discontinued for failure to supply the required documentation shall not be entitled to the procedural rights provided in Articles VII and VIII of these Bylaws.

E. Within 60 days of receipt of the completed application, the chairman of each department in which the applicant seeks privileges shall provide the Standards and Credentials Committee with specific written recommendations relating to staff category, clinical privileges, department affiliations, and any special condition(s) to be attached to the appointment. The department chairman may require an interview with the applicant or additional documentation.

F. Within 90 days of receipt of the completed application, the Standards and Credentials Committee shall make a written recommendation to the Medical Executive Committee (MEC) as to privileges and/or staff membership, and, if staff membership is recommended, as to staff category, privilege delineation, department/service assignment, and any conditions attached to the appointment, based on all available information, including the recommendations from the department chairman and, when required, based also on an interview with the applicant. The recommendation must state that the practitioner be appointed to the medical staff in provisional status or rejected, or that the application be deferred for further consideration.

G. At its next regular meeting after receipt of the recommendations of the credentials committee, the MEC, based on the review of all available information, the report of the credentials committee and, if necessary, an interview with the applicant, shall submit in writing to the governing body its recommendations relating to medical staff membership and, if appointment is recommended, to staff category, to clinical privileges, to any special requirements, and to department affiliation.

The committee may also defer (for cause) action on the application pursuant to subparagraph H below.

H. Action by the Medical Executive Committee:

1. Deferral shall not extend beyond 45 days at which time, or sooner, the MEC will recommend to the governing body, either (a) appointment to the medical staff (or clinical privileges), together with the staff category, a delineation of clinical privileges, and department affiliation, or (b) rejection of the applicant's request for staff membership or clinical privileges.
2. When the recommendation of the committee is favorable to the applicant, the administrator will forward it, together with all supporting documentation, to the governing body at the next regularly scheduled meeting.
3. When the recommendation of the MEC is adverse to the applicant, the administrator shall so inform the applicant within five working days by Certified Mail, Return Receipt Requested, and the applicant shall be entitled to the procedural rights provided in Article VIII of these Bylaws. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, requested staff category, department assignment, or denial or restriction of requested clinical privileges. No such adverse recommendation need be forwarded to the governing body until after the affected individual has exercised or has waived his right to a hearing as provided in Article VIII of these bylaws.

I. Action by the Governing Body:

1. Subject to the provisions of Article VIII of these bylaws, the governing body shall act on the matter at the next regular meeting following receipt of the recommendation of the MEC.

2. If the MEC's recommendation is favorable, the governing body shall, in whole or in part, adopt or reject it, or refer it back to the MEC for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation shall be made. If the governing body's action on such recommendation is adverse to the applicant in any respect, the administrator shall so inform the applicant within five working days by special notice and the affected individual shall then be entitled to the procedural rights provided in Article VIII of these bylaws. Such adverse decision shall not become final until the individual has exercised or has waived his rights under Article VIII of these bylaws and until there has been compliance with subsection I.4 below. The fact that such adverse decision is not yet final shall not be deemed to confer staff membership or privileges when one existed before.

3. At its next regular meeting, after all of the affected individual's rights under Article VIII of these bylaws have been exhausted or waived, the governing body or its duly authorized committee shall act in the matter pursuant to the provisions of Article VIII. All decisions to appoint shall include a delineation of the clinical privileges that the individual may exercise, and an assignment of staff category and department affiliation.

4. Subject to any applicable provisions of Article VIII, a notice of the governing body's final decision shall be given through the administrator to the applicant within five working days

by special notice. The chief of staff shall give notice to the MEC, the Standards and Credentials Committee, and the department chairman.

J. Previously Denied or Terminated Applicants: Notwithstanding any other provision of these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or privileges, or who has had membership and/or privileges terminated, the applicant must provide evidence of any changes to the situation which caused the denial of Staff membership and/or privileges. If it appears that the application is based on substantially the same information as when previously denied or terminated, the application shall be rejected and returned to the applicant as unacceptable for processing. No such application shall be processed, and no right of hearing or appeal shall be available in connection with the rejection or return of such application.

SECTION 6 - THE REAPPOINTMENT PROCESS

A. At least 120 days prior to expiration of current appointment, the administrator shall provide each medical staff member and others with privileges, (except for members of the Honorary Medical Staff, who are exempt from the reappointment requirement) with a "Reappointment Request for Consideration" form to be completed and returned within 30 days, for review by the CPC. Failure without good cause to so return the form shall constitute a voluntary resignation from the staff and shall result in termination of membership at the expiration of the member's current term. A practitioner whose membership is so terminated shall not be entitled to the procedural rights provided in Article VIII.

B. Information to be available at the time of CPC and credentials committee review, as reflected in the credentials files of medical staff members, and to be utilized by the appropriate department chairman, the credentials committee, MEC and the Board of Trustees in making a recommendation for the reappointment of a practitioner, shall include at least the following:

1. Objective evidence of the individual's clinical performance/competence based on the findings of the ongoing departmental quality assessment activities, including an evaluation by the department chairman, and of all medical staff quality-related monitoring activities (committees, etc.). Should insufficient evidence be available on a practitioner due to limited activity at this facility, similar quality assessment data from other area healthcare facilities may be requested to be provided by the practitioner.

2. The medical staff member's support of the medical staff and hospital. This may include medical record deficiency/delinquency status, meeting attendance, service on committees, number of admissions and procedures, compliance with the bylaws, rules and regulations, and policies and procedures, etc.

3. Any request or recommendation for change in staff category, clinical privileges, or department assignment, citing the reasons and supporting information therefor;

4. Evidence of consideration of the staff member's health status with respect to his/her ability to exercise the privileges granted;

5. Any sanctions imposed by another health care facility, professional organization, or licensing authority, including all present hospital/other healthcare affiliations, including voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, loss or denial of clinical privileges at other hospitals;

6. Malpractice/claim experience since the last reappraisal, including pending malpractice claims;

7. Evidence of current licensure and DEA registration, including pending challenges to license or DEA; and

8. Evidence of financial responsibility for professional liability, as meets the requirements of Florida law, as defined in Article III, Section D.9. of these Medical Staff Bylaws.

23. Evidence that the National Practitioner Data Bank has been queried, requesting a practitioner profile for the involved applicant for reappointment.

10. Continuing medical education for the past two years. A minimum of eight (8) hours of continuing medical education in the practitioner's primary specialty is required each biennial reappointment period.

C. At least 60 days prior to expiration of applicant's current appointment and after CPC review, the department chairman shall receive from the administrator the reappointment application and all relevant information. Based on this and any other pertinent information available to him, the department chairman shall render to the credentials committee at its next scheduled meeting a written recommendation concerning the individual department member's reappointment and clinical privileges. When any change is recommended by the department, the reason for such recommendation shall be stated and documented.

D. At least 45 days prior to expiration of applicant's current appointment, the credentials committee shall review all pertinent information and make its written recommendation concerning each staff member's reappointment and clinical privilege delineation to the MEC at its next scheduled meeting. When any change is recommended, the reason for such recommendation shall be stated and documented.

E. At least 30 days prior to expiration of applicant's current appointment, the MEC shall meet and review all pertinent information and make its written recommendation to the governing body at its next regularly scheduled meeting concerning each staff member's reappointment and clinical privilege delineation. When any change is recommended, the reason for such recommendation shall be stated and documented.

F. Thereafter, the procedure provided in Section 5 will be followed.

G. If the processing delay is attributable to the staff member's failure to provide required information, his staff membership shall terminate on the expiration date as provided in Section 6A.

H. A staff member may, either in connection with reappointment or at any other time, request a change of his staff category, department affiliation, or clinical privileges by submitting a written request to the administrator. Such request shall be processed in substantially the same manner as a reappointment.

I. Reappointment to the medical staff obligates the member to abide by the requirements stated in Section 3D, 1-11 above.

SECTION 7 - PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

A. The hospital may determine as a matter of policy that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written agreements between the hospital and qualified professionals. Such agreements may cause staff members, except in emergency or life-threatening circumstances, to observe this exclusivity policy in arranging for the care of their patients. Applications for initial appointment or for clinical privileges related to those hospital facilities and services specified in said agreement(s) will not be accepted for processing unless submitted with confirmation from the administrator of an existing or proposed agreement with the hospital.

B. A practitioner who is providing such contract services to the hospital must meet the same membership qualifications; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

C. In approving any such practitioner(s) for medical staff membership, the medical staff must require that the services provided meet The Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assurance program.

D. Because practice at the hospital is always contingent upon continued staff membership and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use the hospital's facilities is automatically terminated when staff membership expires or is terminated. Similarly the extent of his clinical privileges is automatically limited to the extent that pertinent clinical privileges are reduced or eliminated.

E. Any practitioner whose engagement by the hospital requires membership on the medical staff shall not have his medical staff membership or admitting and clinical privileges terminated without the same fair hearing provisions as must be provided for any other member of the medical staff, unless otherwise stated in the engagement contract.

SECTION 8 - LEAVE STATUS

A. A member may request a voluntary leave of absence from the medical staff by submitting a written request to the administrator who will transmit this notice to the Standards and Credentials Committee and the MEC. The written notice shall state the specific period of time, which may not exceed two (2) years. During the period of leave, the staff member's clinical privileges and prerogatives shall be suspended.

B. At least 30 days prior to termination of the leave, or at any earlier time, the member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the administrator, who will transmit this notice to the Standards and Credentials Committee and the MEC. The member shall submit a written summary, detailing his professional/patient care activities during the leave. The MEC, on receipt of the recommendation of the credentials committee, shall make its recommendation to the governing body concerning the reinstatement of the member's privileges and prerogatives. Thereafter, the procedure provided in Article III, Section 5 shall apply.

C. Failure without good cause to request reinstatement or to provide a summary of professional and other activities as above required shall constitute a voluntary resignation from the staff and shall result in termination of staff membership, privileges, and prerogatives. The MEC shall in its sole discretion, and after giving such practitioner the opportunity to address the committee, determine whether or not good cause existed. A practitioner whose membership is so terminated shall not be

entitled to the procedural rights provided in Article VIII. A request for staff membership subsequently received from a staff member so terminated shall be treated and processed as an application for initial appointment.

D. In the discretion of the governing body, reinstatement may be made subject to an observation requirement for a period of time during which the practitioner's clinical performance is observed by one or more designated clinical department members to determine the practitioner's continued satisfaction of qualifications.

SECTION 9 - RESIGNATION FROM MEDICAL STAFF

A. Any practitioner or anyone with clinical privileges who desires to resign from the Medical Staff (or end their privileges) must submit his letter of resignation, through his assigned department chairman, to the MEC and the chief executive officer, stating such request. The MEC shall forward its recommendation to the governing body.

B. No application for resignation shall be considered until all obligations to the hospital have been satisfactorily completed by the applicant, including completion of all medical records and other arrangements, satisfactory to the hospital, for such conclusion.

C. Any practitioner not complying with the previous paragraph shall be considered as having resigned from the staff with prejudice and this shall be appropriately recorded. Subsequent application for medical staff membership or clinical privileges will not be processed insofar as outstanding obligations remain or are no longer able to be completed. This status will be reported to any requests for references.

SECTION 10 - DURATION OF APPOINTMENT

Duration of appointment shall be for a two (2) year period.

SECTION 11 - MEDICAL STAFF OBLIGATIONS

All members of the Medical Staff, and others with privileges, shall be obligated to inform the MEC of any of the following events, at the commencement of the event:

A. Absences from their medical practice of three months or greater, including the reason for such absence. Practitioners who will be away from their medical practice for a three-month or greater period shall be required to request an official Leave of Absence, in accordance with these Medical Staff Bylaws.

B. A relocation of a practitioner's medical practice to another practice location, including the estimated duration of this practice relocation, the reason for such relocation, and the practitioner's intention concerning his current Medical Staff membership and clinical privileges. All practitioners must keep their current address/phone number on file in the Medical Staff Office where notices may be served.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - MEDICAL STAFF CATEGORIES

The medical staff shall be divided into the following categories: active, affiliate, courtesy, consulting, and honorary.

SECTION 2 - ACTIVE MEDICAL STAFF CATEGORY

The active staff category shall consist of practitioners who (1) have an office-based medical practice and who regularly admit, or personally provide services or consultations to, patients in the hospital and whose office is located within a reasonable distance and/or travel time to the hospital in order to provide continuous care to their patients or (2) are hospital-based physicians, as earlier defined in these bylaws, who do not admit patients (with the exception of anesthesiologists and interventional radiologists, who may admit for out-patient observation only), or (3) are hospitalists.

Active staff members shall admit or provide the above-described services to an average of 12 or more patients per year, and any less than this shall ordinarily be deemed a request for modification of membership status. This requirement may be modified, on a case-by-case basis, if recommended by the appropriate Department Chairman and approved by the Department, the Standards and Credentials Committee, the Medical Executive Committee (MEC) and the Board of Trustees. Active staff members assume the functions and responsibilities of membership including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments.

Members of the active staff shall be eligible to vote; hold staff and departmental office; serve on medical staff, departmental and governing body committees; and shall attend not less than the number of medical staff, departmental, and committee meetings required by these bylaws. Active staff members shall participate in the quality assurance activities required of the medical staff and shall serve, when qualified and required to do so, as proctors for other practitioners during any period of temporary privileges pending staff membership processing or during the initial staff membership provisional status period. When there is a bed shortage, regardless of the reason, active staff members will be granted priority over the members of all other medical staff categories for elective admissions.

After 15 years of satisfactory Active Staff membership, a practitioner shall be eligible to remain on the Active Staff without meeting the requirements of admissions, if so recommended by the appropriate Department Chairman and approved by the Department, the Standards and Credentials Committee, the MEC and the Board of Trustees.

SECTION 3 - COURTESY MEDICAL STAFF CATEGORY

The courtesy staff category shall consist of (1) practitioners who have an office-based medical practice which is located within a reasonable distance and/or travel time to the hospital to provide continuous care for their patients or (2) hospital-based physicians, as earlier defined in these bylaws, who do not admit patients.

A. Courtesy staff members must provide evidence of patient activities during each two (2) year reappointment period to be able to show sufficient evidence of current clinical competency (i.e., sufficient evidence is a minimum of twelve (12) admissions/consultations/surgeries from any area hospital(s) for each two (2) year period of reappointment). If a Courtesy staff member has not had a sufficient number of cases at this hospital during his past reappointment period, he may be requested to provide appropriate documentation from other area hospitals to demonstrate his current clinical competency.

B. Courtesy staff members are not eligible to vote on medical staff or departmental matters, or hold medical staff office. They may serve as voting members of the medical staff as participating members of designated departmental and hospital committees, except for the Standards and Credentials Committee and the MEC. They shall not be required to attend medical staff meetings.

C. At times of shortage of hospital beds or other facilities as determined by the administrator, the elective patient admissions of courtesy staff members shall be subordinate to those of active staff members.

SECTION 4 - CONSULTING MEDICAL STAFF CATEGORY

The consulting staff category shall consist of practitioners of recognized professional ability and stature who have indicated their willingness to accept such appointment. Consulting medical staff members shall have an office-based medical practice or are hospital-based physicians, as defined earlier in these bylaws.

A. Consulting staff members must provide evidence of patient activities during each two (2) year reappointment period to be able to show sufficient evidence of current clinical competency (i.e., sufficient evidence is a minimum of ten (10) admissions/consultations/surgeries from any area hospital(s) or out-patient surgery center(s) for each two (2) year period of reappointment). If a Consulting staff member has not had a sufficient number of cases at this hospital during his past reappointment period, he may be requested to provide appropriate documentation from other area hospitals to demonstrate his current clinical competency.

B. They are not eligible to vote on medical staff or departmental matters, to hold medical staff or departmental office, or to admit patients. They are not required to attend medical staff or departmental meetings, serve on committees, or serve on the emergency room roster. They are required to abide by the bylaws, rules and regulations of the medical staff and governing body and applicable hospital policies. Residence in close proximity to the hospital is desirable, but not required.

SECTION 5 - HONORARY MEDICAL STAFF CATEGORY

The honorary medical staff category shall consist of practitioners who are not active in the hospital and who are honored for emeritus positions. These practitioners may have retired from active practice and may no longer reside in the immediate community. They are not eligible to vote on medical staff matters, hold medical staff or departmental office, serve on committees, or admit or care for patients. They are not required to attend medical staff or departmental meetings, but may do so if they wish. Payment of staff dues is not required.

SECTION 6 – AFFILIATE MEDICAL STAFF CATEGORY

Qualifications – The Affiliate Staff category shall consist of practitioners who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance and/or travel time to the Hospital but who do not admit or provide services within the Hospital.

Affiliate Staff members shall provide satisfactory evidence of training and competency to the Standards & Credentials Committee. Affiliate Staff members are not eligible to vote on Medical Staff or Departmental matters or hold Medical Staff office.

Prerogatives – The prerogatives of an Affiliate Staff member shall be as follows:

- Admit patients through a physician on Staff with admitting privileges. The Affiliate Staff category does not have any clinical privileges associated with it.
- An Affiliate Staff member shall be eligible to serve on Medical Staff Committees, without voting privileges.
- An Affiliate Staff member may make courtesy visits on their admitted/E.R. patients and discuss their care with the attending physician and involved specialists.
- An Affiliate Staff member is allowed to review the current medical record (within the hospital and via the EMR) on their admitted/E.R. patients.
- Affiliate Staff members are encouraged to attend educational Grand Rounds CME conferences at Palms.

Responsibilities – Each member of the Affiliate Staff shall:

- Discharge the basic responsibilities specified in these Bylaws.
- Comply with all qualifications for Staff membership, with the exception of (1) achieving Board certification within 3 years of appointment, and (2) maintaining professional liability insurance.

ARTICLE V
CLINICAL PRIVILEGES

SECTION 1 - EXERCISE OF PRIVILEGES

Every practitioner 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 Section 3 and 4 below, be entitled to exercise only those privileges specifically granted to him by the governing body. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restriction thereon. Regardless of the privileges granted, each practitioner must obtain consultation when necessary for the safety of his patients or when required by these bylaws, the rules and regulations and other policies of the medical staff, any of its clinical units, or the hospital. Practitioners may not practice outside the scope of their granted privileges.

SECTION 2 - DELINEATION OF CLINICAL PRIVILEGES

A. Application. Clinical privileges may be granted only upon formal request on forms provided by the hospital with subsequent processing and approval. Every application for medical staff, LIP or AHP appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a member, or other individual credentialed through the Medical Staff processes, for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

B. Basis for Privilege Determination. Requests for clinical privileges shall be evaluated on the basis of the individual's training, experience, and education; his demonstrated current competence; any required references; and other relevant information, including an appraisal by the chairman of the department or major clinical service in which such privileges are sought, and health status as it may affect the practitioner's ability to exercise the privileges if granted. In granting privileges, consideration must be given to objective information received from sources outside the hospital, to the need for an adequate ongoing experience (volume) to maintain proficiency, to the hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in the determination of clinical privileges.

C. Procedure. All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article III for medical staff membership and/or privileges.

D. Special Conditions for Clinical Privileges. Requests for clinical privileges for podiatrists shall be processed in the manner specified in this Article for other practitioners, and shall be based on their training, experience, education, and demonstrated competence, and the need for their services in the hospital. Surgical procedures that each podiatrist may perform shall be under the overall supervision of the chief of surgery. An adequate history and physical examination on all podiatric patient admissions shall be performed and recorded in the medical record by a physician member of the medical staff. The podiatrist shall be responsible for completing the part of the history and physical examination related to the podiatric problem. A physician member of the medical staff shall be responsible for the care of any medical problem present at the time of admission or that arises during hospitalization.

E. Unavailable Clinical Privileges. Notwithstanding any other provisions of these bylaws, to the extent that any requested clinical privileges are not available at the hospital (whether because of exclusive contract, lack of facilities, policy decision of the governing body, or otherwise), the request therefor shall be rejected without the necessity of processing pursuant to Section 2C above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the procedural rights provided in Article VIII.

SECTION 3 - TEMPORARY PRIVILEGES

A. Pending Appointment to the Medical Staff. Only upon receipt of a completed application, as previously defined in Article III, Section 5.D. of these bylaws, shall an applicant for Medical Staff membership, or clinical privileges, be scheduled for an interview with the Standards and Credentials Committee. Following a satisfactory recommendation from the Standards and Credentials Committee that the applicant be approved for Medical Staff appointment, or clinical privileges, temporary privileges may be granted to the applicant for the pendency of the application process (not to exceed 90 days), through final approval of the application by the Board of Trustees.

Special requirements of consultation and reporting may be imposed by the department chairman for the individual granted temporary privileges. Prior to being granted temporary privileges, the individual must acknowledge in writing that he has received and read the medical staff bylaws, rules and regulations and applicable policies and agrees to be bound by them.

B. Care of a Specific Patient. Temporary privileges may be granted to a practitioner (who is not an applicant for medical staff membership) to assist in the care of a specific patient. In such cases, the practitioner shall submit a completed temporary privileges request form, along with a current curriculum vitae, a photocopy of his current Florida State licensure, current DEA registration, and evidence of financial responsibility for professional liability, as meets the requirements of Florida law, as defined in Article III, Section 3.D.9. of these Medical Staff Bylaws, which will be verified by the CPC and Medical Staff Office personnel. A National Practitioner Data Bank profile must also be obtained prior to the granting of any temporary privileges. Said temporary privileges will only be in effect to provide the requested care for the specific patient.

C. Locum Tenens. A practitioner with appropriate professional qualifications, licensure, and financial responsibility for professional liability, may be granted temporary privileges to serve in a locum tenens status for a period of up to 30 days without having to apply for staff membership. The practitioner shall submit a completed temporary privileges request form, along with a current curriculum vitae and current copies of his Florida State licensure, DEA registration, and evidence of financial responsibility for professional liability, as meets the requirements of Florida law, as defined in Article III, Section D.9. of these Medical Staff Bylaws, which will be verified by the CPC and Medical Staff Office personnel. In addition, the professional education and training of the practitioner, along with his specialty board status and at least one peer reference, will also be verified from primary sources, whenever possible. A National Practitioner Data Bank profile must also be obtained prior to the granting of any temporary privileges. He will be bound by the medical staff bylaws, rules and regulations and any departmental rules and regulations during the time period of his granted temporary privileges.

D. Authority to Grant Temporary Privileges. Upon the written concurrence of the chairman of the department in which the practitioner will exercise temporary privileges and of the chief of staff, the administrator or his designee may grant temporary privileges under the circumstances stated in Sections 3A, B, and C above. In an emergency, verbal concurrence will suffice, to be documented in writing subsequently.

E. Termination of Temporary Privileges. On the discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, or an unfavorable recommendation by the Medical Executive Committee (MEC) as to his application, the administrator may, after consultation with the department chairman (or other medical staff member) responsible for supervision and/or with the chief of staff, terminate any and all of such practitioner's temporary privileges. However, when the life or health of a patient is determined to be endangered by the continued treatment by the practitioner, the termination may be effected by any individual entitled to impose summary suspension under these bylaws. In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the department chairman responsible for supervision or by the chief of staff. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

F. Rights of the Practitioner. No practitioner shall be entitled to the procedural rights afforded under Article VIII of these bylaws because of his inability to obtain temporary privileges or because of any total or partial termination, modification, or suspension of temporary privileges.

SECTION 4 - EMERGENCY PRIVILEGES

In case of an emergency in which serious, permanent, or aggravation of, injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay could add to that danger, any member or (defined) practitioner with clinical privileges is temporarily privileged, and will be assisted by hospital personnel and other available practitioners, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by his license but regardless of department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care. Documentation of the emergency nature of the situation must be accomplished by both medical and hospital personnel. Following resolution of the emergency, the patient's care will be resumed by his/her own practitioner, unless other formal arrangements are made.

SECTION 5 – PRIVILEGES FOR TELEMEDICINE

Telemedicine involves the use of electronic equipment and communication systems to provide or to support clinical patient care at a distance. Those practitioners who diagnose or treat patients via telemedicine systems are subject to the qualifications for membership, and the credentialing process, including appointment, reappointment and privileging, of the healthcare organization where the patient receives the telemedicine services. Appropriate use of telemedicine equipment by physicians is considered as part of the appointment, reappointment and clinical privilege delineation processes.

Prior to a practitioner providing telemedicine services (including the rendering of a diagnosis or other provisions of clinical treatment) to patients at Palms of Pasadena Hospital (i.e., Hospital), the practitioner must be appropriately credentialed and granted appropriate privileges by Hospital. Such practitioner may be credentialed in accordance with Article III, Section 5, of these Bylaws or, at Hospital's discretion, Hospital may rely upon credentialing information (including any documentation required by Hospital) supporting and evidencing the practitioner's current medical staff appointment at the facility from which location s/he will be providing such services (i.e., distant site).

In order for Hospital to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following conditions must be met:

- The distant site must be JCAHO or DNV accredited.
- The practitioner must be privileged at the distant site for the services to be provided at Hospital.
- Hospital has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events, considered reviewable by the JCAHO or DNV that result from the telemedicine services provided, and complaints about the distant site’s practitioner from patients, other practitioners or staff at Hospital.

Practitioners applying to Palms of Pasadena Hospital for the purpose of providing telemedicine services at this facility will be required to comply with Hospital’s Medical Staff Bylaws, with the exception of the following:

- Appear for interview with regard to his/her application, except at the discretion of the Standards & Credentials Committee.
- Department meeting attendance requirements.

In addition, such practitioners (1) may not admit patients to the Hospital and (2) will not be assessed an appointment processing fee or pay biennial dues.

If the privileges of a practitioner who has been credentialed for the sole purpose of providing telemedicine services are suspended, restricted or terminated at the distant site, his/her clinical privileges related to telemedicine at Hospital shall be voluntarily relinquished.

SECTION 6 - DISASTER PRIVILEGES

Practitioners who do not possess medical staff privileges at Palms of Pasadena Hospital may practice at this hospital during an "emergency" (defined as any officially declared emergency, whether it is local, state, or national), only when the Hospital's Emergency Management Plan has been activated and it has been determined the Hospital is unable to meet immediate patient needs. In accordance with the Medical Staff's "Credentialing Volunteer Practitioners in the Event of a Disaster" policy (MSS.005), the individuals responsible for granting disaster privileges are, in this order, (1) the Chief of Staff or designee, or (2) Practitioner Directing Triage, or (3) Administrator On Call. Appropriate identification of the individual requesting disaster privileges must be verified, as established by hospital policy and procedure.

ARTICLE VI
IMMUNITY FROM LIABILITY

A. The following shall be express conditions to any individual's application for, or exercise of, clinical privileges in this hospital:

1. That any act, communication, report, recommendation, or disclosure, with respect to any such individual, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

2. That such privilege shall extend to members of the hospital's medical staff and its governing body, to designated professional personnel providing patient care services in the hospital, to the administrator and his representatives, and to third parties, who supply information and to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article VI, the term "third parties" means both individuals and organizations from which information has been requested and/or received by an authorized representative of the hospital, its governing body, the medical staff, or any committee or component thereof.

3. That there shall, to the fullest extent permitted by law, be immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even when the information involved would otherwise be deemed privileged.

4. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: applications for appointment or clinical privileges; periodic reappraisals for appointment or clinical privileges; periodic reappraisals for reappointment or clinical privileges; corrective action, including summary suspension; hearings and appellate reviews; medical care evaluations; utilization reviews; and other hospital, departmental, service, or committee activities related to the monitoring and maintenance of quality patient care and to appropriate professional conduct.

5. That the acts, communications, reports, recommendations, and disclosures referred to in this Article VI may relate to an individual's professional qualifications, clinical competency,

utilization practices, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

6. That in furtherance but not to exclusion of the foregoing, each individual shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article VI in favor of the individuals and organizations specified in this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness as may be applicable under the laws of this State.

7. That the consents, authorizations, releases, rights, privileges, and immunities provided by other sections of these bylaws for the protection of this hospital's practitioners, designated professional personnel who provide patient care services in the hospital, other appropriate hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article VI.

B. Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to any other protection provided by law and are not in limitation thereof.

ARTICLE VII
CORRECTIVE ACTIONS

SECTION 1 - FORMAL REQUEST FOR CORRECTIVE ACTION

A. Grounds: Initiation. Whenever the conduct of any medical staff member ("affected practitioner") is considered to be lower than the standards of the medical staff; or to be disruptive to the operations of the hospital; or to constitute fraud or abuse; or to constitute a felonious act in this State; or to be detrimental to the quality of patient care at the hospital; or to be detrimental to the hospital's licensure or accreditation; or to be detrimental to hospital or medical staff efforts to comply with any professional review organization, third-party payor (private or governmental), or utilization review requirements; or in violation of these bylaws, or in violation of the rules, regulations, or policies of the hospital, medical staff or any department or committee thereof, corrective action against the affected practitioner may be requested by any member ("requesting party") of the medical staff or governing body or by the administrator. All requests for corrective action shall be in writing, shall be submitted to the Medical Executive Committee (MEC), and shall set forth the specific conduct constituting the basis for the request.

B. Investigation. The MEC, before taking action on the request, shall conduct such investigation as it deems necessary, which may include informal interviews with the requesting party and the affected practitioner (each out of the presence of the other), informal interviews with or reports from other persons, any required or requested departmental review, and chart reviews if applicable. Neither the investigation nor any other activities of the MEC acting upon a request for corrective action shall constitute a hearing; they shall be informal, and none of the procedural rules provided in Article VIII with respect to hearings and appeals shall apply.

C. Time for Taking Action; Notice. Within 60 days after receipt by the MEC of a request for corrective action, or within such reasonable additional time as the MEC deems necessary, the MEC shall take action upon the request. Within five days after taking action, the MEC shall give written notice to the requesting party, the affected practitioner, and the governing body, stating which of the corrective actions set forth in this Section D the MEC has taken.

D. Possible Actions. The action of the MEC on a request for corrective action may be to reject the request; to issue a letter of admonition or reprimand; to impose terms of probation or a requirement of proctoring, co-admitting, or consultation; to recommend reduction, suspension, or proctoring, co-admitting, or consultation; to recommend reduction, suspension, or revocation of clinical privileges; to recommend that an already imposed summary suspension of staff membership or clinical privileges be terminated, modified, or sustained; to recommend that the practitioner's staff membership be suspended or revoked; or to take or recommend other actions deemed appropriate by the MEC.

E. Requesting Party Limitations. The requesting party shall not participate as a member in any meetings, deliberations, or decision of the MEC, any medical review committee or the governing body, relative to the matters raised by or as a result of his request for corrective action, until after the final decision of the governing body has been rendered regarding said matters. The requesting party may, however, contribute to any investigation and be a witness, consultant, or representative at any hearing or appeal held under Article VIII of these bylaws regarding such matters.

F. Notice to Administrator. The chairman of the MEC shall promptly notify the administrator in writing of each request for corrective action received by the MEC and the date of its receipt, and shall keep the administrator fully informed of all communications, meetings, and other actions taken in connection with each request.

G. Right to Hearing. If the affected practitioner or any member of the MEC or governing body is dissatisfied with the action or lack of action by the MEC on a request for corrective action, any of such individuals may request a hearing pursuant to the provisions of Article VIII of these bylaws, provided that the affected practitioner shall have no right to such a hearing when the only action of the MEC was to issue a letter of admonition or reprimand.

H. Retention of Privileges. The affected practitioner shall retain his membership and privileges and the use thereof pending final action by the governing body unless such membership and privileges are otherwise suspended as provided in this Article.

SECTION 2 - SUMMARY SUSPENSION

A. Grounds; Authority. Whenever action must be taken immediately in the best interest of patient care in the hospital, the chief of staff, the chairman of a clinical department, the MEC, the governing body or, if none of the foregoing is available, the administrator, shall each have the right to summarily suspend all or any portion of the privileges of, or to summarily impose consultation, co-admitting, proctoring, and/or similar conditions or restrictions on, a medical staff member ("practitioner"). Such action shall be temporary and shall be effective only until further action by the MEC pursuant to Section 2D hereinbelow.

B. Effective Date; Notice. A summary suspension shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension, stating by whom it was imposed, to the suspended practitioner. Said notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended practitioner, whichever occurs first. Said notice or any subsequent communication shall inform the suspended practitioner of his right to an informal interview upon his written request under Section 2C below, and of his hearing rights under Section 2F below. A copy of said notice shall forthwith be delivered to the administrator, MEC, and the governing body.

C. Investigation. The MEC, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one meeting; an informal interview with the suspending party (if other than the MEC); and an informal interview with the affected practitioner (out of the presence of the suspending party, if other than the MEC) if the affected practitioner requests same in writing within seven days after notice of the suspension was given to him. Such investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing; they shall be informal, and none of the procedural rules provided in Article VIII of these bylaws with respect to hearings and appears shall apply.

D. Further Action; Time. Within ten days after the requested interview date the MEC may take further action with respect to the suspension. Such further action may consist of one of the following alternatives:

1. To terminate the suspension.

2. To sustain the suspension, by one or more of the following methods as deemed appropriate by the MEC:

    a. By making any imposed consultation, monitoring, or similar restrictions effective until altered or terminated pursuant to other provisions of these bylaws. In so sustaining, the MEC may also add further restrictions or substitute other restrictions, which shall also become similarly effective.

    b. By converting a suspension of privileges to a revocation of the same, other, more, or all privileges.

    c. By sustaining the suspension during a period of further investigation deemed necessary.

3. To modify the suspension, by sustaining a portion thereof pursuant to the provisions of Section 2B above, and terminating the remainder thereof.

Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. Failure to take further action within the time period set forth above shall be deemed a decision by the MEC to sustain the suspension, as of the last day of said time period, as follows: by making effective any restrictions that had been imposed and by revoking any privileges that had been suspended.

E. Notice of Further Action. Within five days after taking its further action, the MEC shall promptly give written notice thereof to the suspended practitioner, the administrator, and the person or body who imposed the suspension (if other than the MEC).

F. Rights to Hearing. Following the decision of the MEC regarding further action, the provisions of Article VIII shall govern the rights to hearing and appellate review regarding said decision, provided that only the terms of said decision shall remain in effect. Notwithstanding anything to the contrary in these bylaws, the suspended practitioner shall have no rights to hearing or appellate review if his suspension is terminated, but any member of the MEC or governing body who is dissatisfied with a decision of the MEC that modifies or terminates a suspension may request a hearing pursuant to Article VIII.

G. Alternate Patient Coverage. Immediately upon the imposition of a summary suspension, the chief of staff or responsible departmental chairman shall provide for alternate medical coverage for the patients of the suspended practitioner remaining in the hospital at the time of such suspension, if the appropriate privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternative coverage.

H. Termination of Staff Membership; Readmission. When all of a practitioner's privileges are revoked pursuant to Section 2D above, his staff membership and all attendant rights and prerogatives, except those available rights to hearing and appeal, shall also terminate as of the date of such total revocation, unless and until the MEC, at any time prior to final decision of the governing body, or the governing body in its final decision, reinstates one or more of such privileges or prerogatives. In the absence of such reinstatement, any such practitioner whose staff membership has terminated and who desires to reacquire staff membership and privileges shall make proper and formal application therefor, provided that no such application shall be made or processed within 24 months after the effective date of such termination. Such practitioner, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-time applicants.

I. Privileges Restoration and Restriction Removal. Any particular privilege revoked under Section 2D above may be restored, and any restriction made permanent pursuant to said Section 2D above may be removed, only upon formal application by the practitioner, unless the privilege is restored or restriction is removed by the MEC prior to final decision by the governing body or by the governing body in its final decision. However, no such application shall be made or processed within 12 months after the date such privilege was revoked or such restriction was made permanent, as the case may be. Such practitioner, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-time applicants for the revoked privilege or for those privileges most directly related to the restriction in question, as the case may be.

SECTION 3 - AUTOMATIC SUSPENSION AND EXPULSION

A. Medical Records; Suspension. Subject to applicable law, if any staff member fails to complete the medical records of a patient within the time limits designated in the Rules and Regulations (or such shorter period as the law may prescribe) after the patient's discharge, the administrator shall give the staff member written notice (either by personal delivery or by certified mail, return receipt requested) that such records must be completed within three workdays after the date of the notice, upon penalty of temporary suspension. If the staff member fails to complete such records within the three workday period, a temporary suspension of all privileges shall be imposed automatically by the administrator. Such suspension shall be effective as of the first day after the expiration of the three workday period and shall continue until the medical records in question are satisfactorily completed. With the exception of emergency care, and the care of patients already hospitalized at the time of suspension, such temporary suspension shall include all admitting and clinical privileges, as well as scheduling of elective operations, assisting at elective operations. Unverified emergency admission shall not be used to bypass such restriction. The suspended member shall not attend any patient admitted by another member unless he is the only practitioner available for a specific emergency consultation.

Should the practitioner remain suspended for a period of 30 days, he shall be notified in writing that if his records are not completed within the next 30-day period, he shall be required to appear before the Professional Practice Review Committee to explain why his medical records have not been completed, and that failure to complete said records within these 30 days (or a total of 60

days) may be deemed as a voluntary resignation from staff membership and all privileges, without recourse to the hearing and appeal provisions of Article VIII of these bylaws. Should the practitioner remain suspended for a period of 60 days and/or not provide an acceptable explanation to the Professional Practice Review Committee concerning his incomplete medical records, a recommendation shall be forwarded to the Standards and Credentials Committee to accept the voluntary resignation of the suspended practitioner from the Medical Staff. PPRC shall inform the MEC of all such recommendations at its next regularly scheduled meeting.

B. Medical Records; Report. Subject to and in accordance with applicable law, any staff member accumulating the specified number of automatic suspended days (suspension as defined under Section 3A above) in any one year, shall be reported according to State Law requirements.

C. License; Expulsion. Any individual with privileges whose license to practice is revoked, not renewed, or totally suspended by the applicable state agency shall automatically be expelled from the medical staff or their hospital position, effective upon receipt by the hospital of notice of such official action. The individual will not have the right of hearing or appeal as provided under Article VIII of these bylaws.

D. Drugs and Medicine; Suspension. A temporary suspension of an individual's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall be immediately imposed by the administrator upon the receipt by the hospital of notice that such individual's license to prescribe or obtain controlled substances or medications has been suspended or revoked by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the member's right or license in question, unless the MEC determines otherwise and so notifies the affected individual.

E. Chief of Staff. It shall be the duty of the chief of staff to cooperate with the administrator in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The administrator shall inform the chief of staff of the names of staff members who have been suspended or expelled under this Section.

F. Notices. The administrator shall immediately notify the affected staff member or affected individual with privileges and the chief of staff in writing, either by personal delivery or mail, of any suspension or expulsion under this Section. Such notice shall set forth the effective date of and the reason for the suspension or expulsion.

G. Readmission to Medical Staff after Expulsion. Unless he is reinstated by the governing body in its final decision, any practitioner who is expelled from medical staff membership under Section 3C above and who desires to be readmitted to the medical staff shall make proper and formal application for staff membership, provided that no such application shall be made or processed within 24 months after the effective date of such expulsion. Such practitioner, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-time applicants.

SECTION 4 - OTHER INVESTIGATIVE AND DISCIPLINARY ACTIONS

Notwithstanding anything in these bylaws to the contrary, if the MEC in its sole discretion deems it desirable, it may investigate any matter or any medical staff member or individual credentialed through the Medical Staff processes, brought to its attention by any source and may take any action it deems appropriate with respect thereto, including but not limited to the possible actions set forth in Section 1D

above. Such investigation shall not be deemed a hearing and may be substantially as described in Section 1B above. The MEC shall act with reasonable promptness and shall give notice of any action thus taken or recommended, within five days therefrom, to any affected practitioner or individual and the administrator. Only such affected practitioner or individual shall have a right to request a hearing under Article VIII and only if the action thus taken or recommended falls into one or more of the categories specifically set forth in Article VIII, Section 3B.

ARTICLE VIII
HEARING AND APPELLATE REVIEW PROCEDURES

SECTION 1 - DEFINITIONS

For the purposes of this Article VIII, the following definitions shall apply:

A. "Affected Practitioner" shall mean the medical staff member or applicant for medical staff membership, or other individual credentialed though the Medical Staff processes, with respect to whom any of the actions specified in Section 3B below has been taken or recommended, and whose staff membership or privileges may be affected thereby.

B. "Body whose decision prompted the hearing" shall mean the person, committee, or body (which will generally be the Medical Executive Committee (MEC) that, pursuant to these bylaws, took the action or made the recommendation that resulted in a hearing being requested.

C. "Member who requested the hearing" shall mean the MEC or governing body member, other than the affected practitioner, who, pursuant to these bylaws, was entitled to and has requested a hearing.

D. "Parties" or "party," unless clearly indicated otherwise by particular context, shall mean, collectively or individually as the case may be, the affected practitioner, the MEC, the body whose decision prompted the hearing (if other than the MEC), and, if applicable, the member who requested the hearing.

E. "Recommended" or "recommending," with respect to any of the actions set forth in Section 3B below, shall mean the recommendation made to the governing body by the last committee or body to consider the matter prior to its being referred to the governing body, regardless of whether such recommendation to the governing body was based on any recommendation of another committee or person or otherwise.

SECTION 2 - NOTICES

Each notice given in connection with the provisions of this Article VIII shall be in writing and shall be deemed to have been given on the date on which it is either delivered personally or deposited in the United States mail (postage prepaid, certified with return receipt requested, and addressed to the party at its last known address), whichever occurs first. Each such notice shall be given to each of the parties, and copies thereof shall be as effective as the original for the purpose of giving notice. The administrator shall cooperate and assist in the giving of all notices on behalf of the governing body, the medical review committee (MRC), the MEC, and the body whose decision prompted the hearing, if other than the MEC.

SECTION 3 - ESTABLISHING THE HEARING

A. Notice of Action; Request for Hearing. Whenever any of the actions constituting grounds for hearing set forth in Section 3B below has been taken or recommended, the person, committee, or

body causing same to occur shall forthwith give notice thereof to the affected individual. Said notice shall contain a summary of the rights of the affected individual in the hearing and a brief description of the reasons for the proposed action. Except as specifically set forth in the next sentence, the affected individual shall have 30 days following the date such notice was given within which to request a hearing. Whenever the MEC has given notice of its action taken pursuant to Section 1 of Article VII (regarding a request for corrective action) or of its decision pursuant to Section 2 of Article VII (regarding a summary suspension), the affected individual or any member of the MEC or governing body shall have 15 days following the date such notice was given by the MEC within which to request a hearing, provided that the affected individual shall have no right to such a hearing when the MEC action was to issue a letter of admonition or reprimand. Each such request shall be in writing and shall be delivered to the administrator within the applicable time period set forth hereinabove. Failure of the affected individual, any MEC member, or governing body member to request a hearing within the time and in the manner set forth in this Subsection shall be deemed an acceptance by such party of such action or recommendation and a waiver by such party of all rights to hearing and appellate review with respect thereto. The matter shall thereupon be forwarded to the governing body for its final decision in accordance with Article VIII, Section 7F, 3-5. The administrator shall give notice to all parties of any such waiver and acceptance.

B. Grounds for Hearing. Except as otherwise provided in these bylaws, the taking or recommending of any one or more of the following actions shall constitute grounds for a hearing pursuant to this Article VIII:

1. Denial of initial appointment to staff;

2. Denial of requested advancement in staff category;

3. Denial of staff reappointment;

4. Demotion to lower staff category;

5. Suspension of staff membership;

6. Expulsion from staff;

7. Denial of requested privileges which are offered at the hospital;

8. Reduction in privileges other than in compliance with a policy decision of the hospital;

9. Suspension of privileges;

10. Revocation of privileges other than in compliance with a policy decision of the hospital; or

11. Requirement of consultation or co-admitting other than in compliance with the medical staff bylaws, rules and regulations or departmental rules and regulations.

C. Scheduling of Time and Place for Hearing; Notice:

1. Upon receipt of a proper request for hearing, the administrator shall deliver the request to the MEC, stating the date it was received by the administrator. The MEC shall schedule a hearing and, within 60 days (but in no event less than 30 calendar days prior to the hearing) give

notice to the affected individual of the time, place and date of the hearing. Unless extended by the MRC, the date of the hearing shall not be less than 45 days, nor more than 75 calendar days, from the date of receipt of the practitioner's request for a hearing.

2. If the request is from an individual who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed 10 calendar days from the date of receipt of the individual's request.

3. The above-said notice shall contain the names of the witnesses who are then expected to testify on behalf of the medical staff.

D. Notice of Charges. As a part of, or together with, the notice of hearing, the MEC shall give notice of the acts or omissions with which the affected individual is charged, or a list of chart numbers under question, if any, or the reasons for the action or recommendation. Amendments to the foregoing notice may be made from time to time, but not later than the close of the case by the medical staff representative at the hearing, to reflect the results of any further investigation regarding the affected practitioner. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given forthwith to the affected individual, the MRC Chairman, and each party. If the affected individual promptly gives written request to the MRC, he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The MRC shall give prompt notice to the parties of each such postponement.

E. Medical Review Committee; Appointment, Removal, and Qualifications. Promptly after a hearing has been properly requested, the chief of staff [or alternatively the MEC] shall appoint a medical review committee ("MRC") and a chairman thereof to act as the peer review group in the hearing. The MRC shall consist of not less than five nor more than nine members of the Medical Staff. At any hearing session or time of formal action, a majority of the MRC shall be present. Any member or all members of the MRC may be replaced by the chief of staff [or alternatively the MEC] at any stage of the hearing, and a member must be replaced or dismissed if the member misses three consecutive sessions. At the discretion of the chief of staff [or alternatively the MEC], the number of members in the MRC may be decreased at any time during the hearing process without the necessity of starting the hearing anew, provided that there is a reasonable basis for the reduction, such as the unwillingness of one or more members to continue and provided further that the resulting number shall not be less than five. They may have knowledge of the matters to be heard, but each shall be willing to hear the matters objectively and without prejudgment and shall not have participated in bringing charges or in officially reviewing said matters at any prior time. No person who is in direct economic competition with the affected individual shall be appointed to the MRC.

F. Postponements and Extensions. After the appointment of the MRC and before the commencement of the hearing, postponements beyond the times required by these bylaws may be requested by any of the parties, and may be permitted by the MRC for good cause. The MRC shall promptly give notice to the parties of each such postponement.

G. Medical Staff Representative. After a hearing has been properly requested, the chief of staff [or alternatively the MEC] shall promptly appoint a medical staff member ("medical staff representative") to present the case on behalf of, and otherwise represent, the body whose decision prompted the hearing. The chief of staff [or alternatively the MEC] may, in its sole discretion, remove or replace the medical staff representative at any time.

SECTION 4 - HEARING PROCEDURE

A. Prehearing Procedure. The MRC Chairman may confer with parties involved in the hearing to encourage an advance mutual exchange of documents which are relevant to the issues to be presented at the hearing.

B. Failure to Appear. Failure of the affected individual to appear at the hearing shall be deemed to constitute the affected individual's voluntary acceptance of the recommendation or action involved and waiver of all rights to hearing and appellate review, unless the MRC finds good cause for such failure, based upon written request by the affected individual or his representative.

C. Representation. The hearings provided for in these bylaws are for the purpose of a collegial resolution of matters bearing on conduct or professional competency. As limited by this Section 4C, each of the parties shall have the right to representation at the hearing. Subject to reasonable restriction by the MRC Chairman as to the number of representatives, such representation may consist of one or more attorneys and one or more staff members or non-staff medical practitioners. Any party may obtain legal counsel for the purpose of preparing for the hearing. Only one representative for each party shall be designated as the spokesman for the party, and the other representatives, if any, shall not speak out except with the permission of the MRC Chairman. Neither party shall be able to utilize an attorney as its spokesman at the hearing. A representative may also be a witness.

D. Transcription of Proceedings. The MRC proceedings shall be taken and transcribed by a court reporter, and a copy of the transcript of each session shall be made available to each party and to each member of the MRC, at the expense of the hospital.

E. Oath of Witnesses. The MRC may, in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.

F. Organization and Conduct of Hearing Process. The hearing shall be conducted as follows:

1. The Chairman of the MRC shall conduct the hearing and rule on procedural matters. The MRC Chairman shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. The MRC shall have access to advice from legal counsel, if desired.

2. The medical staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove.

3. The medical staff representative shall then present the facts upon which he is relying, by calling the witnesses and/or presenting the written evidence to support the case. He may call any person or opposing party, who is present, in support of the case.

4. At the close of the medical staff representative's case, the affected practitioner or his representative shall make an opening statement and shall make a case presentation of evidence and/or testimony. He may call any person or opposing party, who is present, in support of the case.

5. Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the MRC Chairman as to order, time, relevance, and repetition.

6. Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the MRC Chairman, to give closing statements and argument.

7. Upon the close of all presentations, rebuttals, statements and argument, the MRC Chairman shall declare the hearing finally adjourned, and all persons other than the MRC shall thereupon leave the hearing. The MRC shall thereafter, at the convenience of its members but subject to the provisions of Section 5 below, deliberate in order to reach its decision.

8. Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the MRC Chairman after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only.

9. No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the MRC Chairman to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the MRC Chairman, leave the hearing. Unless directed otherwise for good cause by the MRC Chairman, the hearing shall proceed in the absence of such excluded person. If such excluded person is the affected individual or a witness, he shall have the right to submit to the MRC, not later than ten days after such exclusion (unless extended by the MRC Chairman for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties. Any party may enforce the provisions of this Section 4.F.9 by court order upon a request for injunctive or other appropriate relief.

10. Except as otherwise provided in these bylaws and subject to reasonable restriction by the MRC Chairman, the following shall be permitted to attend the entire hearing in addition to the MRC, court reporter, and parties: the administrator, one or more persons designated by the administrator, the medical staff services director or assistant, one or more key consultants for each party, one or more key witnesses for each party, and one or more representatives of the entity that owns the hospital.

G. Burden of Proof. Each party shall support its case by substantial evidence, except that the affected individual (or the member who requested the hearing, if other than the affected practitioner) shall have the additional burden of proving, by clear and convincing evidence, that the action or recommendation of the MEC, which is the subject matter of the hearing, was arbitrary, unreasonable, or not supported by substantial evidence.

H. Admissible Evidence and General Procedures. Except as otherwise provided in these bylaws, the following rules shall apply in the hearing with respect to evidence and briefs:

1. The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law.

2. Parties, representatives, and any member of the MRC shall have the right to

   a. ask MRC members questions directly related to whether they are impermissibly biased, subject to reasonable restriction by the MRC Chairman to prevent abuse of the right, and to challenge such members;

   b. call and examine witnesses on relevant matters;

   c. introduce relevant exhibits;

   d. cross-examine each witness on relevant matters, after such witness testifies on direct examination;

   e. present evidence that tends to impeach any witness on relevant matters, provided that, to prevent abuse of this right, the MRC Chairman may, in his discretion, require a prior offer of proof summarizing such evidence and may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justifies such rejection.

   f. call and examine the individual under review, as if under cross-examination.

3. Evidence of relevant activities or practices at any location or facility shall be admissible unless limitations are imposed by the MRC Chairman upon a showing of good cause.

4. No legal doctrine shall prevent the introduction of any evidence or the reassertion of any charge, but this entire Section 4H shall not be used to avoid the prohibition of Section 8 below against more than one hearing on any issue, unless substantial evidence is offered that was not available at the time of the prior hearing.

5. The MRC may receive and consider any brief or memorandum presented by any party.

6. Any relevant material contained in medical staff files regarding the affected individual is admissible, including but not limited to applications, references, and accompanying documents.

7. The MRC shall have the discretion to recognize any matters, either technical or scientific, relating to the issues under consideration, which are common knowledge in the general medical community and/or any medical specialty.

8. Statistic evidence of morbidity and/or mortality is admissible if relevant, and may be sufficient by itself to establish a controverted fact.

SECTION 5 - DECISION AND REPORT OF MRC: NOTICE

Within 30 days after final adjournment of the hearing, the MRC shall render and deliver to the administrator a decision that shall be in the form of a recommendation to affirm, terminate, or modify the action or recommendation that prompted the hearing, and if to modify, the recommended modifications shall be set forth. Said decision shall be based on substantial evidence produced at the hearing, including any recognized matters, and reasonable inferences that may be drawn therefrom. Said decision and a concise statement of the MRC's findings and reasons justifying the decision shall be contained in a written report of the MRC. The administrator, within five days after receiving the report, shall give notice

of said decision, including a copy of said report, to the governing body, the affected individual, the MEC, and each other party (if any).

SECTION 6 - GOVERNING BODY ACTION AFTER MRC DECISION

The governing body shall take no action regarding the underlying matter or the decision and report of the MRC, until after the expiration of the time for requesting appellate review under Section 7A below, provided that if an appellate review is properly requested under said Section 7A, the governing body shall take no action except in compliance with the procedures and provisions of this Article VIII. If an appellate review is not properly requested under said Section, and the time therefor has expired, the governing body shall make its final decision in accordance with Section 7F.

SECTION 7 - APPEAL TO GOVERNING BODY

A. Time for Requesting Appeal. Within 30 days after the giving of notice to the parties of the decision of the MRC, the affected individual, the body whose decision prompted the hearing, any member of the governing body, or the MEC (if other than the body whose decision prompted the hearing) may request an appellate review by the governing body. The request shall be in writing and shall be delivered in person or mailed to the administrator, who shall immediately deliver copies of same to the governing body and to the other parties. The request shall also set forth the ground or grounds for appeal on which it is based. If an appellate review is not requested as set forth above in this Section 7A, all parties shall be deemed to have waived all rights to appeal same.

B. Nature and Effect of Appellate Review. The appellate review shall be by the governing body or a committee thereof (and all references hereinafter to the "governing body" shall include such committees). Appellate review shall consist of a review of the prior proceedings and decision in the matter being reviewed, an appellate review meeting, deliberations, review of any further recommendations, and a final decision. In its final decision the governing body may affirm, deny, modify, or reverse the underlying action or recommendation of the MEC. No governing body member who participated as a medical staff member in bringing the charges or in officially reviewing the matter shall participate in the appellate review process, even if such removal leaves the governing body with less than a quorum.

C. Grounds for Appeal. The grounds for appeal are: substantial and prejudicial failure of the MRC or the MEC to comply with these bylaws or to afford due process or a fair hearing; the action or recommendation that prompted the hearing, or any substantial part thereof, was arbitrary, unreasonable or capricious; or the MRC's decision or any substantial part thereof was clearly contrary to the weight of the evidence; or that a medical staff bylaw, rule or regulation relied on by the MRC in reaching its decision lacked substantive rationality.

D. Time, Place, and Notice of Appellate Review Meeting. The governing body shall, within 30 days after receipt by the administrator of a timely request for appeal, schedule a date for an appellate review meeting. The governing body shall, not less than ten days prior to the date of the appellate review meeting, give the affected individual and each other party written notice of the time, place, and date thereof. The date therefor shall be not less than ten days, nor more than 60 days from the date of receipt by the administrator of the request for appellate review, except that when a request for appellate review is from a member who is then under suspension, the appellate review meeting shall be held as soon as reasonably practicable but not later than 40 days from the above-said date of receipt of the request. The date for the appellate review meeting may be extended by the chairman of the governing body for good cause, but for not more than an additional 20 days except with the written consent of the affected individual. Failure to hold an appellate review meeting within the time limits set forth in this Section 7D, including any extensions authorized by the

governing body, shall be deemed an affirmation by the governing body of the last decision of the MEC.

E. Appellate Review Proceedings. The appellate review proceedings shall be conducted as follows:

1. The governing body shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written briefs submitted by the parties. The governing body may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for MRC hearings. Such acceptance of additional issues or evidence may be based on the governing body's own motion, or upon the request of a party if, not less than seven days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the governing body to do so, specifying the nature and relevance of the issues or evidence, and gives notice of such request to all other parties. The governing body shall give notice of its decision in such matters to all parties as soon as reasonably possible.

2. The governing body may, in its sole discretion, appoint a hearing officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the governing body as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision. Such hearing officer may be one who conducted the MRC hearing, if other than the chairman of the MRC.

3. Each party shall have the right to submit a written brief in support of his position on appeal, provided that copies of such brief shall be given to all other parties not less than seven days prior to the date of the appellate review meeting.

4. The governing body, in its sole discretion, may allow each party or his representative to appear personally and make oral argument at the appellate review meeting, provided that such party shall make written application therefor to the governing body not less than seven days prior to the date of the appellate review meeting. The governing body shall give notice of its response to such applications to all parties as soon as reasonably possible. If personal appearance is allowed, the affected individual, if present, and all other parties and representatives present, shall answer any questions posed by any member of the governing body.

5. The governing body may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it decides, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter. The governing body shall give notice to the parties of any such future date and time, unless the parties were present when such date and time were announced by the governing body.

6. At the conclusion of the appellate review meeting, including oral argument, if allowed, the governing body shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, deny, modify, or reverse the underlying action or recommendation of the MEC.

7. The governing body shall, in its sole discretion, decide the order of procedures to be followed in the appellate review, as well as answers to questions not otherwise addressed in these bylaws, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair.

8. No person shall disrupt any appellate review proceeding. Any person in attendance (whether a party or any other person) who disrupts an appellate review meeting after being warned by the chairman of the governing body (or his designee or the hearing officer) to cease such disruption on penalty of indefinite exclusion shall, at the direction of such chairman (or his designee or the hearing officer), leave the meeting. Unless directed otherwise for good cause by the chairman (or his designee or the hearing officer), the appellate review meeting shall proceed in the absence of such excluded person. Any party may enforce the provisions of this Section 7.E.8. by court order upon injunctive or other appropriate relief.

F. Final Decision; Effective Date. The appellate review process shall conclude with the governing body's final decision in the matter, which shall be made in accordance with and subject to the following rules:

1. Within 30 days after the conclusion of the appellate review meeting, the governing body shall render its final decision, unless it refers the matter to the MEC for further review and recommendation.

2. If the governing body refers the matter to the MEC for further review and recommendation, such referral may include instructions such as that the MEC arrange for further hearings on specific issues. The governing body shall forthwith give notice of such referral to the parties. The MEC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the governing body within 45 days after the receipt of the referral from the governing body. Within 45 days after receipt of such recommendation, the governing body shall render its final decision.

3. If the final decision of the governing body is in accordance with the action or recommendation of the MEC, it shall be effective immediately and not subject to further hearing or appeal.

4. If the final decision is not in accordance with the action or recommendation of the MEC, such final decision of the governing body shall not yet be effective, and the governing body shall refer the matter to a joint committee, composed of two medical staff members (who are not governing body members) chosen by the chief of staff and three governing body members, chosen by the chairman of the governing body, for further review and recommendation within 45 days. The governing body shall forthwith give notice of such referral to the parties. At its next meeting after receipt of such joint committee's recommendation, the governing body shall again render its final decision, which may or may not be in accordance with that of either the MEC or the joint committee, and which shall be effective immediately and not subject to further hearing or appeal.

5. The governing body's final decision shall be in writing and, as soon as it is effective under this Section 7.F., copies thereof shall be delivered forthwith to the affected individual, the administrator, and each other party, in person or by mail. Said final decision shall include a statement of the governing body's basis for its decision.

SECTION 8 - RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one MRC hearing and one appellate review on any matter that may be the subject of an MRC hearing or appeal.

SECTION 9 - INFORMAL INTERVIEWS

Nothing in these bylaws shall be deemed to prevent any committee or person contemplating any action or recommendation set forth in Section 3B above, from inviting the affected individual to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article VIII.

SECTION 10 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these bylaws, whenever the affected individual unconditionally (a) resigns from the medical staff; (b) resigns and relinquishes the privileges that are the subject matter of a hearing; (c) withdraws the application that is the subject matter of a hearing; (d) amends an application or request so as to remove the items that are the subject matter of a hearing, or (e) consents in writing to the action of recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appellate review proceedings with respect to said individual, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the governing body, after receiving a written request from, or giving notice to, the affected individual ~~practitioner~~, and determining that good cause exists for such reopening.

SECTION 11 - SETTLEMENTS

If a proposed settlement of the subject matter for which a hearing is pending is agreed upon between the affected individual and the MEC, such proposed settlement may be submitted in writing directly to the governing body for its rejection or approval. If the governing body rejects such submitted settlement, the settlement shall thereupon terminate as if it had never been agreed upon. If the governing body approves such a submitted settlement, it shall render its final decision in the matter forthwith in accordance with the settlement, which final decision shall be effective immediately and shall not be subject to further hearing or review. Failure of the governing body to reject or approve such a settlement within 30 days after its submission to the governing body shall be deemed a final decision to approve same by the governing body.

SECTION 12 - CONFIDENTIALITY OF PROCEEDINGS

Except as otherwise authorized in these bylaws or by law, all parties, participants, and attendees shall keep the hearing and appellate review proceedings and the content thereof confidential, and no one shall disclose or release any information from or about the proceedings to any person or the public. Any party or participant who is damaged by a violation of this Section may enforce this Section by court order upon request for injunctive or other appropriate relief.

ARTICLE IX
OFFICERS OF THE MEDICAL STAFF

The Officers of the medical staff shall be:

A. Chief of Staff
B. Vice Chief of Staff
C. Secretary-Treasurer
D. Immediate Past Chief of Staff

The Vice Chief of Staff shall automatically succeed the Chief of Staff.

SECTION 1 – QUALIFICATIONS

Officers must be members of the active staff at the time of their nomination and election, must have been on the active staff for a minimum of two (2) years, and must remain in good professional and ethical standing during their term of office. Because of the peer responsibilities of their offices, the chief of staff and vice chief of staff shall be physicians, with demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of medical staff activities. Officers must have demonstrated good interpersonal relationships with medical staff members and hospital staff, and have indicated a willingness to accept the responsibilities of the office.

SECTION 2 - NOMINATION AND ELECTION OF OFFICERS

Officers shall be elected by active staff members at the final meeting of the designated medical staff term. Election shall be by oral vote or showing of hands unless written ballot is requested by two or more eligible voters. The candidate must be elected by a majority vote of the active staff members present at the meeting. When three or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted.

A. Nominations may be made:

1. by a nominating committee. The nominating committee shall consist of no fewer than three (3) members of the active staff and shall include the current Chief of Staff, the three (3) most recent Chiefs of Staff who are available to serve, and the current Vice Chief of Staff, who shall serve in an ex officio capacity. The Chief of Staff will act as Chairman of the Nominating Committee. This committee will meet as needed and recommend a slate of active staff physicians for consideration. This slate will be presented to the Medical Executive Committee (MEC) for approval at least six (6) weeks prior to the election.

2. by petition. Nominating by petition requires the signatures of at least ten percent (10%) of the voting active staff members, with written consent to serve of the nominee, and must be filed with the Medical Staff Office at least ten days prior to the final medical staff meeting. The medical staff shall be notified of these additional nominees at the time of this meeting.

SECTION 3 - TERM OF OFFICE

Each officer shall serve a one-year term, beginning the first day of the medical staff term following their election. Each officer shall serve until the end of his term or until a successor is elected, unless he shall sooner resign or be removed from office.

A. Vacancies in Office. Vacancies in office during the medical staff term, except for the chief of staff and vice chief of staff, shall be filled by the MEC. If there is a vacancy in the office of chief of staff, the vice chief of staff shall serve out the remaining term. A vacancy in the vice chief of

staff's office shall be filled by a special medical staff election held at the next regularly scheduled general meeting or through a medical staff meeting called for this specific purpose as soon as reasonably possible after the vacancy occurs.

SECTION 4 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

Removal of a Medical Staff officer for cause may be initiated by petition of an active staff member in writing to the MEC. An adverse recommendation must be approved by two-thirds (2/3) vote of the full MEC, then by seventy-five percent (75%) vote of all active staff members with voting privileges by written ballot. No such removal from office shall become effective unless and until it has been ratified by the Governing Board.

Each of the following conditions in itself constitutes cause for removal of a staff officer from office:

A. Revocation of professional license by the authorizing state agency.
B. Suspension from the medical staff (other than for delinquent medical records).
C. Failure to perform the required duties of the office.
D. Failure to adhere to professional ethics.
E. Failure to comply with or support enforcement of the hospital and medical staff bylaws, rules and regulations, and policies.
F. Failure to maintain adequate financial responsibility for professional liability, as meets the requirements of Florida law, as defined in Article III, Section D.9. of these Medical Staff Bylaws.
G. Failure to maintain Active staff status.
H. Other conditions, as approved by the MEC.

SECTION 5 - RESPONSIBILITIES, DUTIES, AND AUTHORITY OF OFFICERS

A. The responsibilities, duties, and authority of the chief of staff are as follows:

1. Calls, presides at, and determines the agenda of all general and special meetings of the medical staff;

2. Serves as chairman of the MEC, with tie-breaking vote prerogative only, and as ex officio member of all other medical staff committees without vote;

3. Is responsible for enforcement of medical staff bylaws, rules and regulations and appropriate hospital rules and policies; for implementation of sanctions when they are indicated; and for the medical staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a practitioner;

4. Appoints the chairman and all medical staff members of medical staff standing and ad hoc committees, except the MEC and Standards and Credentials Committee; appoints the medical staff members of hospital and governing body committees when these are not designated by position or by specific direction of the governing body;

5. Represents the views, policies, concerns, needs and grievances of the medical staff to the governing body and administration; serves ex officio as a voting member of the governing body;

6. Advises the governing body on the effectiveness of the quality assurance program and the overall quality of patient care in the hospital;

7. Advises the governing body, administration, and the MEC on matters that impact on patient care and clinical services, including the need for new or modified programs/services, for recruitment and training of professional and support staff personnel, and for staffing patterns; and

8. Serves as spokesman for the medical staff in its external professional and public relations.

B. The responsibilities, duties, and authority of the vice chief of staff are as follows:

1. Assumes the responsibilities, duties, and authority of the chief of staff during the latter's absence whether the absence is temporary or permanent; and

2. Is an ex officio voting member of the MEC.

3. Automatically assumes position of Chief of Staff at the end of the term of the Chief of Staff.

C. The responsibilities, duties, and authority of the immediate past chief of staff are as follows:

1. Serves as an ex officio voting member of the MEC;

2. Advises the chief of staff and the MEC on matters concerning the medical staff;

3. Performs other functions at the request of the chief of staff;

4. Assumes the responsibilities, duties, and authority of the chief of staff when both the latter and the vice chief of staff are temporarily absent.

D. The responsibilities, duties, and authority of the secretary-treasurer are as follows:

1. Serves as an ex officio voting member of the MEC;

2. Responsible for maintaining accurate and complete minutes of all medical staff meetings;

3. Responsible for giving proper notice of all medical staff meetings on order of the chief of staff;

4. Is responsible for maintaining a record of medical staff dues, collections, and accounts, and is authorized to sign checks for medical staff fund expenditures.

SECTION 6 - REMOVAL OF MEDICO-ADMINISTRATIVE OFFICER

A. Purely Administrative Responsibilities. Practitioners employed or contracted by the hospital in a purely administrative capacity, with no clinical duties, will be subject only to the regular personnel policies of the hospital and, if applicable, to the terms and conditions contained in their agreements with the hospital; such officers need not be members of the medical staff. Hospital policies and agreements will prevail in removal of such practitioners.

B. Medico-Administrative Positions. Practitioners who have an agreement with the hospital, either full-time or part-time, in a medico-administrative position that includes staff clinical responsibilities or functions, must be members of the medical staff. In addition to any applicable terms of the agreement, such practitioners shall achieve staff membership and clinical privilege delineation through the same procedure as is required for other medical staff members. Any practitioner so engaged by the hospital shall not have his staff membership or clinical privileges terminated without the same procedural provisions provided other members of the medical staff (Articles VII and VIII of these bylaws), unless otherwise specifically stated in the agreement between such practitioner and the hospital. Any contractual details regarding termination of staff membership or privileges without the procedural provisions of Articles VII and VIII will be disclosed to the governing body at its request.

SECTION 7. EXECUTIVE COMMITTEE

The following officers shall compose the Executive Committee of the MEC and shall act between meetings of the MEC upon call by the Chief of Staff:

A. Chief of Staff.
B. Vice Chief of Staff.
C. Secretary-Treasurer.
D. Immediate Past Chief of Staff.
E. Chief of Appropriate Department.

The Executive Committee shall only act upon matters requiring immediate action. All actions shall be reported to the MEC at the next regularly scheduled meeting and shall be subject to the approval of the MEC.

ARTICLE X
CLINICAL DEPARTMENTS

SECTION 1 - ORGANIZATION

A. Each department shall be organized as a separate part of the medical staff and shall have a chairman who shall be responsible for the overall supervision of the clinical work within his department and is selected and has the authority, duties, and specific responsibilities as specified in this Article. Each department shall also have a vice chairman and at least four members.

B. There shall be departments of Emergency Service, Medicine, Diagnostic and Therapeutic Radiology, and Surgery.

1. The Medicine Department shall include the following practice specialties: allergy, cardiology, dermatology, endocrinology, family practice, gastroenterology, geriatric medicine, hematology, infectious disease, internal medicine, nephrology, neurology, oncology, infectious disease, internal medicine, nephrology, neurology, oncology, psychiatry, pulmonology, and rheumatology.

2. The Surgery Department shall include the following: general surgery, thoracic surgery, vascular surgery, neurosurgery, orthopedic surgery, plastic surgery, urologic surgery, gynecology, ophthalmology, otorhinolaryngology, maxillofacial surgery, general dentistry and all dental specialties, colon/rectal surgery, podiatric surgery, and the clinical services of anesthesiology and pathology.

3. The Diagnostic and Therapeutic Radiology department shall consist of a clinical service of diagnostic radiology and a clinical service of therapeutic radiology.

C. When deemed appropriate for better organizational efficiency and improved patient care, the Medical Executive Committee (MEC), with the approval of the governing body, may create new, eliminate, subdivide, or combine clinical departments.

D. When clinical services are established, they shall be organized as a specialty subdivision within a department, shall be directly responsible to the department within which it functions, and shall have a chief of service who is selected and has the authority, duties, and responsibilities as specified in this Article.

E. A group of practitioners of the same specialty that desires to become a clinical service must have a recommendation for such from the parent department to the MEC. Denial of such a request by the department must be accompanied by the reason for the denial. The MEC and the governing body will then act on the request as follows:

1. If the MEC approves a positive recommendation from the department, the recommendation is forwarded to the governing body.

2. If the MEC disapproves a positive recommendation from the department, the issue can then be referred to the next general medical staff meeting. The recommendation of the medical staff will then be forwarded to the governing body.
3. If a negative recommendation from the department is supported by the MEC ~~Medical Council~~, the issue is considered closed.

4. If the MEC reverses a negative decision from the department, the department may request that the issue be referred to the next general medical staff meeting. The recommendation of the medical staff will then be forwarded to the governing body.

5. All final approval rests with the governing body.

SECTION 2 - ASSIGNMENT TO CLINICAL DEPARTMENTS

A. Each member of the medical staff, ILP or AHP, shall be assigned membership in one clinical department, based on the bulk of the clinical services he provides. Members may, in addition, be granted clinical privileges in one or more other departments.

B. Each practitioner will be allowed to vote in only one department and to represent only one department on committees (including the MEC), and shall be responsible for attending the required number of meetings only in the department to which he is primarily assigned. However, each practitioner is encouraged to attend meetings in all departments in which he exercises privileges and should keep himself informed of departmental activities, particularly as they relate to findings of patient care evaluation activities.

C. The exercise of clinical privileges granted by the governing body or the performance of specified services within any department shall be subject to the rules and regulations of that department and the defined authority of the department chairman.

D. Individuals classified as designated professional personnel, regardless of source of employment and the degree of practice independence, shall be assigned to a department for control and

performance evaluation purposes and shall be subject to all applicable departmental, medical staff, and hospital rules and regulations. Attendance by such individuals at department meetings shall be determined by the department chairman.

SECTION 3 - FUNCTIONS OF CLINICAL DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct ongoing specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided through the department. To carry out this responsibility, each department either alone or in concert with other organizational components of the medical staff and of the hospital, shall:

A. Objectively review, analyze and evaluate the quality of care provided through the department. In the interest of achieving a high quality of patient care, each department, through an established system, shall evaluate all clinical work performed under its jurisdiction, whether or not any particular practitioner or other individual with clinical privileges whose work is subject to such evaluation is a member of the department.

B. Establish criteria for the granting of clinical privileges and, as appropriate, for the holding of office within the department.

C. Recommend to the credentials committee the specific clinical privileges that each staff member or medical staff applicant may exercise in the department, and the specific services that each individual designated professional personnel may provide.

D. Establish such committee or other mechanisms as are necessary and desirable to perform quality assurance functions properly.

E. Monitor its members' performance on an ongoing and concurrent basis for:

1. Adherence to medical staff, hospital, and departmental rules and regulations, and policies/procedures;

2. Meeting requirements for alternate coverage and for obtaining consultation;

3. Adherence to sound principles of clinical practice;

4. Appropriate surgical and other patient care interventions;

5. Unexpected clinical occurrences;

6. All relevant aspects of patient safety.

F. Fulfill the responsibilities designated to the department as set forth in the quality assurance plan.

G. Receive and evaluate the compliance with medical necessity (admission and intervention) and clinical management criteria, the findings from use of occurrence screening criteria, reports of medical staff and other departmental committees, and compliance with the established patient care requirements (rules, regulations, policies, protocols) of the department and medical staff.

H. Coordinate with nursing and ancillary clinical patient care services, and with other administrative support services, the patient care provided by the department's members.

I. Conduct or participate in, and make recommendations regarding, the need for continuing education programs, pertinent to state-of-the-art changes, and, in particular, to the findings of quality assurance review and evaluation activities.

J. Maintain a permanent record of all department meetings/activities to include the discussion content as well as conclusions reached or actions taken or recommended. Copies of minutes should be transmitted to the MEC and quality assurance reports to the quality assurance committee.

SECTION 4 - DEPARTMENT CHAIRMAN AND VICE CHAIRMAN

A. Qualifications. Each chairman and vice chairman shall be a member of the active staff, qualified by training, experience, and demonstrated ability for the position. Each shall have demonstrated professional ability in at least one of the clinical areas covered by the department, shall meet all state regulatory requirements, and shall be willing, able, and eligible to discharge faithfully the functions of his office.

B. Election. Each chairman and vice chairman shall be elected by the active voting department membership from nominees submitted by department members, and shall be subject to approval of the Chief of Staff, the MEC and Board of Trustees, except for Department of Diagnostic and Therapeutic Radiology and Department of Emergency Services in which other provisions may be made by contractual arrangements.

C. Terms of Office. Department chairmen and vice chairman shall serve a three-year term beginning on the first day of the medical staff term following his selection. A department chairman or elected department vice chairman may succeed himself. The department chairman or elected department vice chairman shall serve until his successor is chosen, unless he shall resign sooner or be removed from office. In the temporary or permanent absence of the department chairman, the department vice chairman shall assume all the duties, responsibilities, and authority of the department chairmanship, and will become a member of the MEC.

D. Removal of Department Chairman or Vice Chairman. Removal of a department chairman or vice chairman for cause may be initiated by the governing body acting upon its own recommendation, or upon the recommendation of the MEC, or by a two-thirds majority vote of the department members eligible to vote. Grounds for removal for cause shall include the list under Section 4A of Article IX of these bylaws, relating to removal of medical staff officers.

E. Responsibilities, Duties and Authority of a Department Chairman. Each chairman shall:

1. Account to the MEC for all professional and administrative activities within his department.

2. Develop and implement in cooperation with the chief of staff and consistent with these bylaws, departmental mechanisms for performing the credentials review, delineating clinical privileges, and assigning staff classification; concurrent monitoring of practice, to include an occurrence screening program and the use of medical necessity and clinical management criteria; quality assurance activities; continuing medical education; and utilization review.

3. Transmit to the credentials committee the department's recommendation concerning appointment and reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners in the department.

4. Maintain ongoing review of the professional performance of all practitioners and any designated professional personnel within the department and report regularly thereon to the Standards and Credentials Committee and the MEC, on request and at time of reappointment. The report will include evidence of consideration of each practitioner's health status.

5. Submit periodic (bimonthly) reports to PPRC concerning the department's performance improvement activities.

6. Serve as a member of the MEC in accordance with Article XI, Section 2, Paragraph A., giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his own department in order to promote a high quality of patient care. Within the department, he shall implement actions taken by the MEC.

7. Enforce the hospital and medical staff bylaws, rules and regulations, and policies, and the departmental rules and regulations within the department, including, when appropriate, the initiation of corrective action and investigation of clinical performance/competence, and the ordering of required or needed consultations.

8. Actively encourage all department members to complete adequately the medical records of their discharged patients on time (within the period required by these bylaws, rules and regulations, and by any regulatory agency).

9. Assign proctors to individuals who have been granted temporary privileges prior to staff membership approval or who are in provisional status as newly appointed staff members or as otherwise requested by the MEC.

10. Cause departmental rules and regulations relating to standards of patient care to be developed, approved, implemented, and reviewed at least every three years for any needed revision. The Chiefs of Service of Diagnostic Radiology and Therapeutic Radiology will develop rules and regulations relating to their specific service.

11. Cause all standing orders of practitioners to be reviewed initially, on change, and annually, if the responsibility is not assigned to a standing committee of the medical staff.

12. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the MEC, the administrator, or the governing body.

13. Determine who, outside of the department members, the chief of staff, administrator or designee, QRM Director/Manager and recording secretary, may attend department meetings.

14. Assist with the integration of the department or service into the primary functions of the Hospital.

15. Share resources/services provided by the department with other clinical and ancillary departments.

16. When requested, make recommendations for a sufficient number of qualified and competent persons to provide care or service and for all other resources needed by the department.

17. Oversee the orientation and continuing education of all persons in the department or service.

18. Assess and recommend to the relevant hospital authority offsite sources for needed patient care, treatment and services not provided by the department or the organization.

19. Determine the qualifications and competence of credentialed department personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

20. Recommend space and other resources needed by the department.

21. Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the chief of staff, the MEC, or the governing body.

SECTION 5 - CHIEF OF (CLINICAL) SERVICE

A. Qualifications. Each clinical service chief shall be a member of the active medical staff and a member of the specialty service that he is to head; shall be qualified by training, experience, interest, and documented current ability in the clinical area embodied by the service; and shall be willing and able to discharge the administrative requirements of the office.

B. Selection. The chief of service shall be selected by the voting members of the service, and shall be subject to the approval of the department, the MEC, and the Board of Trustees, except for Pathology Service, Anesthesia Service, Diagnostic Radiology Service, and Therapeutic Radiology Service, in which other provisions may be made by contractual arrangements.

C. Terms of Office; Removal from Office. Each chief of service shall serve a three-year term beginning on the first day of the medical staff term following his selection. A chief of service may succeed himself. Removal of a chief of service may be initiated for cause and carried out as provided for department chairmen and medical staff officers by these bylaws.

D. Responsibilities, Duties, and Authority of a Service Chief. Each chief of service shall:

1. Account to the department and the MEC for the effective operation of the service, including all professional and administrative activities;

2. Develop, implement, and enforce, in cooperation with the department chairman, programs to perform the quality-of-care evaluation and maintenance functions delegated to his service;

3. Exercise general supervision over all clinical work performed through the service;

4. Act as presiding officer at all service meetings and cause a permanent meeting report to be maintained and distributed as required; and

5. Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the department, the MEC, or the governing body.

ARTICLE XI
COMMITTEES AND FUNCTIONS

SECTION 1 - GENERAL CONSIDERATIONS

A. There shall be standing and special (ad hoc) committees of the medical staff. All committee (other than the Medical Executive Committee (MEC) and the Standards and Credentials Committee) members, including the chairman, shall be appointed and/or removed by the chief of staff with the approval of the MEC.

B. Each committee shall submit a copy of its minutes to the MEC, and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions. Each committee shall submit reports from each meeting on quality assurance activities to the quality assurance committee.

C. Nonphysician members participating in committee functions shall be selected by the administrator with the concurrence of the committee chairman or chief of staff.

D. Ex officio committee members shall serve without vote, unless otherwise specified. However, nonphysician committee members shall not vote on issues that specifically require the background of a physician to make such a determination.

E. Whenever these bylaws require that a function is performed by:

1. A named medical staff committee but no such committee exists, the MEC shall perform the function.

2. The MEC, but a standing or special committee has been formed to perform that function, the committee so formed shall act in accordance with the authority delegated to it by the MEC.

SECTION 2 – The MEDICAL EXECUTIVE COMMITTEE

A. Composition. The Medical Executive Committee (MEC) shall be a standing committee of the medical staff and shall consist of the officers of the staff; the past chief of staff; the chairmen of the departments of Emergency Service, Medicine, and Surgery; the service chiefs of anesthesiology, pathology, diagnostic radiology, and therapeutic radiology; three at large members elected by the medical staff, who cannot be hospital-based physicians; one representative from the department of Surgery, elected for one year terms by the department, four representatives from the department of Medicine, at least one of whom must be a family practitioner, elected to one year terms by the department; and the Chairmen of the Standards and Credentials Committee, PPRC and the Pharmacy & Therapeutics Committee. Provision shall be made to stagger the three (3) year terms of the at large members so that at least one (1) shall be elected each year. The chief of staff shall be chairman of the committee and shall vote only to resolve a tie vote. Each voting MEC member, regardless of staff, department, or other committee positions held shall have only one vote. The Administrator or his designee and the CNO shall serve as an ex-officio member. The Board of Trustees Chairman may attend the MEC meetings in an ex-officio capacity.

All voting members of the MEC shall be members in good standing of the Active medical staff for a minimum of two (2) years. Members of the Active (Provisional) Staff are not eligible to serve on Medical Council, with the exception of those Department Chiefs who are appointed to serve by

contractual arrangement. In those instances, the Active (Provisional) member will be nonvoting until they fulfill the above criteria.

Vacancies shall be filled as follows: 1) at large members may be appointed by the Chief of Staff to complete the unexpired term; 2) department chiefs, division chiefs, and department representatives will be elected by the department or clinical service at the next regularly scheduled department meeting.

B. Responsibilities, Duties and Authority. The responsibilities, duties and authority of the MEC shall be to:

1. Represent and act on behalf of the organized medical staff between medical staff meetings, subject to such limitation as may be imposed by these bylaws.

2. Recommend to the governing body on all matters relating to appointments, reappointments, clinical privileges, staff category and clinical department/service assignments, and corrective action, including medical staff terminations. When designated professional personnel, regardless of their source of employment, provide or are recommended to provide services in the hospital, the committee shall make recommendations to the governing body on their qualifications to provide those services and on the degree of supervision required.

3. Request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

4. Receive and act upon reports and recommendations from medical staff committees, all clinical departments/services, and staff officers concerning quality assurance activities and the discharge of their delegated administrative responsibilities.

5. Cause, through evaluation by this committee or the performance improve committee, each medical staff peer evaluation and quality maintenance activity to be performed effectively, particularly in instances where there is doubt about an applicant's ability to perform the privileges requested.

6. Coordinate the activities of, and policies adopted by, the staff, departments/services, and committees.

7. Fulfill the medical staff's accountability to the governing body for the medical care rendered to patients in the hospital.

8. Initiate and pursue corrective action, when warranted, in accordance with these bylaws.

9. Take all reasonable steps to help assure professional ethical conduct, competence, and clinical performance on the part of all staff members.

10. Make recommendations to the governing body on medico-administrative and hospital management matters (particularly as they relate to patient care) through the administrator and chief of staff.

11. Submit recommendations to the governing body for changes in the medical staff bylaws, rules and regulations and other organization documents pertaining to the medical staff.

12. Provide and promote effective liaison among medical staff, administration, and governing body.

13. Participate in identifying community health needs and in setting hospital goals and implementation of programs to meet those needs.

14. Actively promulgate effective medical staff participation in the occurrence screening program.

15. Strive to assure that in-house medical staff continuing education activities are relevant to the care and services provided in the hospital and, in particular, to the findings of medical staff peer evaluation and quality maintenance activities.

C. Meetings. The MEC shall meet at least monthly.

SECTION 3 - STANDARDS AND CREDENTIALS COMMITTEE

A. Composition. The Standards and Credentials Committee shall consist of five (5) active staff members, each of whom has been on the active staff for a minimum of five (5) years. The members shall serve staggered terms of three (3) years each and shall be elected in accordance with Article IX, Section 2, paragraph A of these Bylaws. Membership shall be distributed in the following manner: two members from the department medicine and one member from the department of surgery, and two at-large members. The Standards and Credentials Committee shall elect its own chairman on an annual basis.

B. Committee Functions. The responsibilities, duties and authority of the credentials committee shall be to:

1. Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment, and for clinical privileges, and in connection therewith, to obtain and consider the recommendations of the appropriate departments.

2. Review requests for laser privileges and make recommendations to grant approval or suggest additional training.

3. Review and evaluate the qualifications of designated professional personnel, regardless of their source of employment, to provide specific (patient care) services in the hospital, and in connection therewith, to obtain and consider the recommendations of the appropriate department.

4. Submit a report, in accordance with these bylaws, to the MEC on the qualifications of each applicant for staff membership or clinical privileges, and of each designated professional personnel, to provide specific (patient care) services. Such report shall include recommendations for staff applicants as to appointment, staff category assignment, department/service affiliation, and clinical privileges, and for designated professional personnel, the specific services to be performed. In either case, any special conditions attached thereto will be recommended at the same time.

5. Submit monthly reports to the MEC on the status of pending applications, including the specific reasons for any unusual delay in processing an application or request.

6. Monitor activities implemented for evaluation of the performance of patient care, such as for practitioners in provisional status or who have been granted temporary privileges pending medical staff appointment.

7. Assure that a separate credentials file is maintained for each staff member, each practitioner with clinical privileges, and each designated professional personnel, including reports from quality assurance activities and of corrective actions of any degree.

C. Meetings. The credentials committee shall meet at least bimonthly or more often, if necessary.

SECTION 4 - PROFESSIONAL PRACTICE REVIEW COMMITTEE (PERFORMANCE IMPROVEMENT COMMITTEE)

A. Composition. The performance improvement committee shall be a standing committee of the medical staff and shall consist of five to ten physician members of the active medical staff category. The CEO or his designee, the COO, the CNO, and the QRM Director/Manager, shall serve as ex officio members. The Board of Trustees and each clinical medical staff department shall be represented on the committee. Other individuals from either the medical or hospital staffs may participate as consultants on an as-needed basis.

B. Responsibilities, Duties and Authority. The responsibilities, duties, and authority of the performance improvement committee shall be to:

1. Coordinate and integrate all quality assessment components of the quality assurance program to reduce/eliminate duplications, omissions, inconsistencies, and failure to effect change.

2. Require that all evaluations performed are objective (based on preset criteria or standards), are clinically rather than administratively oriented, and are designed to identify important problems/patterns of care and performance. The committee, through its quality assurance coordinator, may assist in providing suitable clinically valid criteria for use in quality assessment activities.

3. Monitor the quality assurance program to the extent that it is comprehensive, in that all departments/committees/services/specialties/units/practitioners/allied health personnel are evaluated through the system in place. This applies to Medical Staff Departments, Medical Staff Committees, and Hospital Departments. All Medical Staff Departments and Committees are responsible for conducting and reporting to the MEC, through PPRC, regarding results of the monitoring and evaluation of generic quality screens, medical record review function, blood and drug utilization, and surgical case review including indications for surgery. Hospital Departments are responsible for conducting and reporting results of monitoring and evaluation via the use of indicators and criteria.

4. Monitor corrective action to determine if it has been taken, is effective, and is maintained. Physician-related corrective action will be the responsibility of the MEC. Hospital-related corrective action will be the responsibility of administration. The governing body will assess the medical staff and administration effectiveness in assuring any corrective action needed.

5. Receive, analyze, and recommend action regarding any significant findings from the occurrence screening program.

6. Maintain liaison with risk management, utilization review, infection control, patient representative, and in-service education.

7. Maintain a current written quality assurance plan.

8. Perform at least an annual evaluation of the quality assurance program to assure the comprehensiveness and effectiveness of the departmental monitoring and evaluation activities and the organizationwide program.

9. Report at least quarterly to the MEC and the governing body and at any time a significant quality-related problem exists.

10. Initiate, investigate, review, and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any practitioner or other individual with privileges, assigned or referred by the chief of staff, department or committee, or governing body. PPRC may meet with any practitioner or other individual with privileges, as part of the investigation process. Said meeting shall be informal in nature and shall not constitute a hearing. The involved practitioner or individual may not be represented by an attorney at this meeting. PPRC may issue letters of warning and/or letters of education to any practitioner or individual under investigation. All other corrective action shall be the responsibility of the MEC.

11. Review, evaluate and make recommendations of reports submitted by departments relating to surgical case evaluation, medical records review, drug therapy evaluation, and blood utilization review in accordance with the hospital's quality assurance plan.

C. Meetings. PPRC shall meet at least bimonthly. Special meetings may be called by the chairman as required.

SECTION 5 - PHARMACY AND THERAPEUTICS COMMITTEE

A. Composition. The Pharmacy and Therapeutics Committee is a standing committee of the medical staff and shall consist of five physicians from the active category of the medical staff. The pharmacist, and a representative from administration, nursing services and nutrition services shall serve as ex-officio members.

B. Responsibilities, Duties and Authority. The responsibilities, duties and authority of the Pharmacy and Therapeutics Committee are to take all reasonable steps to:

1. Cause an objective evaluation of the clinical use of all drugs (by individual drug or category of drug) in the hospital. Special emphasis will be given to known high-risk, problem-prone drugs.

2. Cause a well controlled formulary to be established and implemented. The committee will evaluate and make recommendations to the MEC as to which drugs should be added to and deleted from the formulary. Requests for formulary changes from individual medical staff members may be submitted to the committee in writing, to include the rationale for the change. The committee's action shall be transmitted to the requesting practitioner by the committee chairman.

3. Evaluate all significant untoward reactions to drugs. In addition, the committee shall strive to assure the adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic in-service training for nursing service personnel.

4. Evaluate all significant medication errors, to include reviewing and making recommendations related to overall medication use and aggregate medication error data.

5. Assist in the formulation of and approve all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the hospital.

6. Help assure the centralized function and adequacy of intravenous admixtures, total parenteral nutrition, and admixture of chemotherapeutic agents.

7. Make recommendations to the MEC regarding protocols proposed for the use of investigational or experimental drugs in the hospital.

8. Make recommendations to the MEC regarding protocols proposed for the use of high-risk and problem-prone drugs in the hospital.

9. Cause the objective ongoing evaluation of the clinical use of all antibiotics in the hospital, whether the drugs are prescribed prophylactically, empirically, or therapeutically and whether administered to inpatients, outpatients, emergency room patients, or hospital-sponsored home care patients. The committee shall recommend action for any required practice change to the MEC and shall follow up through the quality assurance committee to be sure the approved change has occurred. The committee shall recommend and/or approve criteria for use in all facets of antibiotic use evaluation.

10. On an ongoing basis, review and revise as necessary all standing orders of the hospital and medical staff.

C. Meetings. The Pharmacy and Therapeutics Committee shall meet at least quarterly.

SECTION 6 - INFECTION CONTROL COMMITTEE

A. Composition. The Infection Control Committee is a standing committee of the medical staff and will consist of at least three physicians from the active category of each major department of the medical staff, a clinical pathologist, a representative from administration and from nursing services, and the individual(s) responsible for infection control surveillance activities in the hospital. Other individuals, representing the operating room, pharmacy, housekeeping and laundry, engineering and maintenance, central services, dietetic services, respiratory care services, etc., shall participate as consultants on an as-needed basis when their area is involved.

B. Responsibilities, Duties and Authority. The responsibilities, duties, and authority of the infection control committee shall be to prevent, investigate, and control infection in the hospital by

1. Maintaining surveillance of hospital infection potentials.

2. Developing a system for identifying, reporting, and analyzing the incidence and major causes of hospital-acquired and nosohusial infections.

3. Developing and implementing, through administration and the medical staff, a preventive and corrective program designed to minimize infection hazards, and to include an employee health program. This program will also include the satellite facilities.

4. Actively promoting the adequate application of general policies and procedures relating to infection control for all units/areas of the hospital and satellite facilities, to include, but not limited to, isolation procedures and techniques, sterilization procedures, the safe disposal of infectious or contaminated wastes, prevention of cross-infection through equipment use (e.g., anesthesia, respiratory care, physical therapy, etc.).

5. Instituting any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel. When the situation is considered to be urgent, the committee chairman or a physician member of the committee may institute the control measure immediately and will be assisted by hospital personnel in doing so. The chief of staff and administrator shall be notified as soon as any urgent control measure is instituted and shall be consulted prior to any nonurgent measure being instituted. When the issue involves the care of a private patient, the attending practitioner shall be notified as soon as possible; however, when the patient's attending practitioner does not consider the measure necessary (e.g., the need to isolate a patient), the decision of the committee chairman or member, following established infection control policy, shall prevail.

C. Meetings. The Infection Control Committee shall meet quarterly.

SECTION 7 - BYLAWS, RULES AND REGULATIONS COMMITTEE

A. Composition. The bylaws, rules and regulations committee is a standing committee of the medical staff and shall consist of three or more physician members of the active staff category of the medical staff. A representative of administration and the medical staff services professional shall participate as ex officio members of the committee without vote.

B. Responsibilities, Duties and Authority. The responsibilities, duties, and authority of the bylaws, rules and regulations committee shall be to:

1. Cause, through ongoing review, that the bylaws, rules and regulations reflect current practice, national standards of patient care, and an efficient organization of the medical staff to perform its functions;

2. Recommend to the MEC and the governing body any changes deemed necessary or desirable in the bylaws, rules and regulations;

3. Cause each clinical department to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with medical staff bylaws, rules and regulations, Local, State and Federal Law, The Joint Commission, and with hospital and governing body policies; and

4. Act as the medical staff mechanism for documenting the required annual review of the medical staff bylaws, rules and regulations, making at that time, any recommendations for change.

C. Meetings. The bylaws, rules and regulations committee shall meet as often as required, but at least once per year.

SECTION 8 - UTILIZATION REVIEW/MEDICAL RECORDS COMMITTEE

A. Composition. The utilization review committee is a standing committee of the medical staff and shall consist of at least five physicians from the active category of the medical staff, including at least one member from each of the Departments of Internal Medicine and Surgery. Members of the committee are appointed for staggered terms of two (2) years so their terms do not expire concurrently. Ex-officio membership shall represent administration, utilization review, medical records, nursing and social services.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the Utilization Review Committee shall be to

1. Comply with all requirements of the utilization review plan approved by the medical staff and governing body;

2. Require documentation that utilization review is applied regardless of payment source;

3. Require that focused reviews be emphasized; and

4. Determine whether under utilization and, when appropriate, over utilization practices impact adversely on the quality of patient care and recommend the appropriate action to be taken.

5. Monitor the medical record review function and medical record completion statistics, to insure compliance with The Joint Commission standards, Federal and State of Florida law, and to identify opportunities for improvement.

6. Review and approve all forms that are made part of the permanent medical record.

7. Act in an advisory capacity regarding medical record issues such as storage, microfilming, suspension policy, etc.

C. Meetings. The Utilization Review Committee shall meet at least bimonthly.

SECTION 9 - INTENSIVE CARE COMMITTEE

A. Composition. The Intensive Care Committee is a standing committee of the medical staff and shall consist of at least five members of the active medical staff, including physicians who frequently utilize the intensive care units, in addition to the medical directors/advisors of the intensive care units. Ex-officio membership shall represent administration, nursing, quality assurance and respiratory therapy.

B. Responsibilities, Duties and Authority. The responsibilities, duties and authority of the Intensive Care Committee shall be to:

1. Formulate and recommend policies and procedures for the intensive care units.

2. Review, evaluate and make recommendations on the quality of patient care rendered in the intensive care units.

C. Meetings. The Intensive Care Committee shall meet at least quarterly.

SECTION 10. EDUCATION AND LIBRARY COMMITTEE

A. Composition. The Education and Library Committee is a standing committee of the medical staff and shall consist of no less than five (5) members of the active staff, with the medical staff librarian as an ex officio member. There shall be a committee chairman and a co-chairman of the library.

B. Responsibilities, Duties, and Authority. The responsibilities, duties and authority of the Education and Library Committee shall be to

1. Schedule educational meetings that meet the needs of the medical staff, particularly as identified through quality assurance activities;

2. Organize and maintain the resources of the medical staff library; and

3. Under direction of the Secretary/Treasurer of the Medical Staff, maintain records of medical staff dues, collections, and accounts. We only have now - or want - ONE person writing checks.)

C. Meetings. The Education and Library Committee shall meet every six months, or more often, as required.

SECTION 11 - PARTICIPATION IN INTERDISCIPLINARY HOSPITAL COMMITTEES

The chief of staff shall appoint, with the approval of the administrator, physician members to certain hospital committees. This will include the safety committee, the disaster planning committee, and any other appropriate committee.

SECTION 12. ETHICS COMMITTEE

A. Composition. The Ethics Committee shall be a standing committee of the medical staff. Membership shall be twelve (12) to eighteen (18) members, of whom nine (9) to twelve (12) shall be physician members appointed by the MEC and three (3) to six (6) shall be nonphysician members appointed by the Ethics Committee. The medical members shall include the current Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff. The other medical members shall be appointed by the Chief of Staff, each of whom has been on the active staff for a minimum of two (2) years and shall include adequate representation from all clinical departments, to include a neurologist. The nonphysician members should represent a broad diversity of background which may range from clergy to social workers to nursing. Members of the committee are appointed for staggered terms of two (2) years so their terms do not expire concurrently. Each member's two-year term may be renewed for an indefinite period of time, at the discretion of the Chief of Staff and the individual Committee member, to provide for

continuity of membership. Ex officio members include the administrator or his designee, director of nursing, hospital chaplain and chairman of the governing board.

B. Responsibilities, Duties and Authority. The Ethics Committee assists in the interpretation of ethical policies established by the Board of Trustees and the Medical Staff. The committee may also be called upon to serve in an advisory fashion to the Board of Trustees and Medical Staff in formulating ethical guidelines and policies and in ethical matters of patient care.

C. Meetings. The Ethics Committee shall meet on a PRN basis but at least twice per year or more often as required.

SECTION 13. HOSPITAL TRANSFUSION COMMITTEE

A. Composition. The Hospital Transfusion Committee shall be a standing committee of the medical staff and will consist of at least five physicians from the active category, to include each major department/service of the medical staff which routinely orders blood, an oncologist, an anesthesiologist, the transfusion service medical director, and representatives from administration, nursing services, quality resource management, health information services, and the individual responsible for transfusion service activities in the hospital.

B. Responsibilities, Duties and Authority. The responsibilities, duties, and authority of the transfusion committee shall be to:

1. Evaluate the appropriateness of all cases in which patients were administered transfusions, including the use of blood and blood components; re-evaluate identified problems to assess improvement.

2. Evaluate all confirmed transfusion reactions and make recommendations to the medical staff regarding improvements in transfusion procedures.

3. Review ordering practices for blood and blood products and promote continuing education in transfusion practices.

4. Develop or approve policies and procedures relating to the distribution, handling, use and administration of blood and blood components.

5. Review the use of various blood administration devices, including filters, warmers, blood pumps and intraoperative autologous transfusion devices.

6. Review and analyze the statistical reports of the transfusion service.

7. Review the adequacy of transfusion services to meet the needs of the patients.

8. Submit quarterly reports to PPRC and the MEC, as required.

C. Meetings. The Hospital Transfusion Committee shall meet at least quarterly.

ARTICLE XII
MEETINGS

SECTION 1 - GENERAL STAFF MEETINGS

A. Regular Meetings. Regular meetings of the medical staff shall be held quarterly. The annual general medical staff meeting shall be the last meeting before the end of the designated medical staff term. Elections for staff office, and Medical Executive Committee (MEC) and Standards and Credentials Committee members will be held at this meeting. The chief of staff shall preside at all general meetings of the medical staff.

B. Order of Business and Agenda. The order of business and agenda of a general staff meeting will be determined by the chief of staff.

C. Special Meetings. Special meetings of the medical staff may be called at any time by the chief of staff and shall be called at the written request of the administrator, governing body, the MEC, or at least one-fourth of the active staff members. The chief of staff shall call a special meeting within seven days of his receipt of written request for same.

1. Written or printed notices stating the place, day, and hour of any special meetings of the medical staff shall be delivered, either personally or by mail, to each member of the active staff not less than three nor more than ten days before the date of such meetings, by or at the direction of the chief of staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his address as it appears in the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting.

2. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 - COMMITTEE, DEPARTMENT, AND CLINICAL SERVICE MEETINGS

A. Medical staff committees, departments, and clinical services may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these bylaws.

B. A special meeting of any committee, department, or clinical service may be called by or at the request of the chairman or chief thereof, by the chief of staff, or by one-third of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C. Notice of Meetings (Committee, Department, Clinical Service)

1. Notice of regular meetings may be given orally.

2. For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day, and hour of the meeting shall be given to each member not less than five days before the time of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital, with postage thereon prepaid.

D. The attendance of a member at a meeting shall constitute a waiver of notice of such meetings.

SECTION 3 - QUORUM

A quorum shall be presumed to be present at any staff, service or committee meeting until adjournment, notwithstanding withdrawal of members following establishment of a quorum.

A. General Staff Meetings (regular or special).

1. The presence of one-fourth (1/4) of the voting members of the medical staff at any regular or special meeting shall constitute a quorum for the purpose of amendment to these bylaws, rules and regulations and the election of staff officers and for the transaction of all other business.

2. In the absence of a quorum, the chief of staff may direct a ballot by mail with the approval of the majority present.

B. Committee, Department, Clinical Service Meetings.
At least ten percent (10%) of the voting members of a committee, department, or clinical service, or not less than two members, shall constitute a quorum at any meeting.

SECTION 4 - MANNER OF ACTION

A. Except as otherwise specified herein, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.

B. Action may be taken without a meeting by a committee, department, or clinical service by a writing setting forth the action so taken and signed by a majority of the members entitled to vote thereat.

SECTION 5 - MEETING MINUTES

Minutes of all meetings shall be prepared by the secretary of the meetings, and shall include a record of attendance and the vote taken on each matter. The minutes shall also record a brief discussion of all problems discussed, indicating any recommendations made and forwarded, conclusions reached, and actions taken. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting (and the actions taken without an actual meeting) shall be maintained.

SECTION 6 - ATTENDANCE REQUIREMENTS

A. Regular Attendance. Each member of the active staff shall be required to attend the following: one-third (1/3) of the combined total of department and general staff meetings for each two-year reappointment period. Attendance at Medical Staff Committee meetings will also count towards satisfying the requirements of this provision.

B. Absence from Meetings.

1. Failure to attend one-third (1/3) of the combined total of general staff and department meetings for a year, without an excuse acceptable to the MEC, or other service acceptable to the MEC in lieu of attendance, shall automatically cause the member to be reclassified as a member of the courtesy medical staff for the next two-year reappointment period. The practitioner may reapply for Active Staff status after one year, provided he has attended a minimum of one-third (1/3) of the combined total of general staff and department meetings held during that one-year period.

2. The meeting attendance record of each practitioner shall be maintained and made a part of his credentials file.

C. Special Attendance Requirements.

1. A practitioner whose patient's clinical course of treatment is scheduled for discussion at a general medical staff, committee or department meeting at which corrective action against the practitioner might result shall be so notified by the chairman and provided an opportunity to attend the meeting. The notification shall indicate the time and place of the meeting, a statement of the issue(s) involved and, whenever apparent or suspect deviation from standard clinical practice is involved; the fact that the practitioner's appearance is mandatory. Notice of mandatory appearance will be made at least ten (10) days prior to the meeting by certified letter.

2. Failure of a practitioner to attend any meeting with respect to which he was given notice that his attendance was mandatory, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical

privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the governing body, if necessary, pursuant to Articles VII and VIII. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate excuse that his absence will be unavoidable, such presentation may be postponed by the chief of staff, or by the MEC if the chief of staff is involved, until not later than the next regular staff, committee, or department meeting; otherwise the pertinent clinical information available shall be presented and discussed as scheduled.

SECTION 7 - NONVOTING EX OFFICIO MEMBERS

Individuals serving under these bylaws as nonvoting ex officio members of a committee shall, unless otherwise specified, have all other rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum.

SECTION 8 - MEETING AS A COMMITTEE-OF-THE-WHOLE

Notwithstanding any other provision of these bylaws, whenever the medical staff or a department or service meets, it shall be considered to be meeting as a committee of the whole medical staff, department, or service, respectively.

SECTION 9 - CONDUCT OF MEETING

All meetings shall follow an acceptable form of parliamentary procedure, such as Robert's Rules of Order Newly Revised Edition, in the conduct of meeting business.

ARTICLE XIII
AMENDMENT OF BYLAWS

Medical staff bylaws may be adopted, amended, or repealed by the following actions:

A. Any proposed change in the medical staff bylaws shall be submitted to the Bylaws, Rules and Regulations Committee, which shall review it and report its recommendations to the Medical Executive Committee (MEC). The MEC shall then present its recommendation at the next regular meeting of the medical staff or at a special meeting of the medical staff called for such purpose.

B. The proposed change(s) shall have been made available to the medical staff members through the designated mechanism; e.g., posting in medical staff lounge, by electronic media and copies available in the Medical Staff Office at least ten days before the medical staff meeting at which a vote is to be taken.

C. To be adopted by the medical staff, a proposed change shall require a two-thirds vote of the active staff members present, provided the required quorum is present, or by a majority vote of returned ballots of active staff members in a mail ballot.

E. The proposed change is then effective as part of the bylaws when approved by the governing body.

F. The MEC may make minor corrections and changes to the Medical Staff Bylaws/Rules & Regulations when such correction or change is necessary for spelling, punctuation and grammar. No prior notice of such change is required. All changes thus made will be reported at the next regular Staff meeting. All such changes shall be immediately effective and remain so unless the Governing Board takes further action to the contrary.

The Medical Staff shall conduct an annual review of the appropriate bylaws, rules and regulations and other organizational documents pertaining to the Medical Staff.

ARTICLE XIV
RULES AND REGULATIONS

A. Medical Staff Rules and Regulations. The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. The rules and regulations shall relate to the proper conduct of medical staff organizational activities and will embody the specific standards and level of practice that are required of each medical staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the hospital. Such rules and regulations may be amended or repealed at any regular meeting of the Medical Executive Committee (MEC) at which a quorum is present, and without previous notice, or at any special meeting of the MEC on notice, by a two-third's vote of the MEC members present. All such changes in the rules and regulations shall not become effective until approved by the governing body.

B. Departmental Rules and Regulations. Each department established through these bylaws shall formulate and implement rules and regulations, after approval of the MEC and governing body. Departmental rules and regulations shall be consistent with these bylaws, with the medical staff rules and regulations, and with established hospital policies, and will include standards of care and practice for department members.

ARTICLE XV
GOVERNING BODY PREROGATIVE IN ESTABLISHING MEDICAL STAFF BYLAWS

The medical staff bylaws and rules and regulations shall be adopted by the medical staff and approved by the governing body before becoming effective. Neither body may unilaterally amend the medical staff bylaws or rules and regulations.

ARTICLE XVI
PATIENT ADMISSION

Every patient must be admitted, and continuously cared for during their entire hospitalization, by a properly credentialed member of this Medical Staff who holds appropriate privileges, to ensure high quality medical care.

APPROVALS/REVISION:

Adopted by Medical Staff:	January 30, 1986
Approved by Governing Board:	February 18, 1986
Amended by Medical Staff:	May 28, 1987
Approved by Governing Board:	June 16, 1987
Amended by Medical Staff:	May 25, 1988
Approved by Governing Board:	June 20, 1988
Amended by Medical Staff:	November 19, 1988
Approved by Governing Board:	January 17, 1989
Amended by Medical Staff:	May 25, 1989
Approved by Governing Board:	June 20, 1989
Amended by Medical Staff:	February 22, 1990
Approved by Governing Board	March 20, 1990
Amended by Medical Staff:	May 31, 1990
Approved by Governing Board:	June 19, 1990
Amended by Medical Staff:	January 6, 1992
Approved by Governing Board:	January 28, 1992
Amended by Medical Staff:	January 28, 1993
Approved by Governing Board:	February 19, 1993
Amended by Medical Staff:	May 27, 1993
Approved by Governing Board:	June 29, 1993
Amended by Medical Staff:	August 25, 1994
Approved by Governing Board:	September 27, 1994
Amended by Medical Staff:	May 23, 1996
Approved by Governing Board:	May 28, 1996
Amended by Medical Staff:	May 8, 1997
Approved by Governing Board:	May 27, 1997
Amended by Medical Staff:	February 19, 1998
Approved by Governing Board:	February 24, 1998
Amended by Medical Staff:	March 17, 1998
Approved by Governing Board:	March 24, 1998
Amended by Medical Staff:	August 20, 1998
Approved by Governing Board:	August 25, 1998
Amended by Medical Staff:	February 25, 1999

Approved by Governing Board:	March 23, 1999
Amended by Medical Staff:	May 27, 1999
Approved by Governing Board:	June 22, 1999
Amended by Medical Staff:	December 15, 2000
Approved by Governing Board:	December 19, 2000
Amended by Medical Staff:	February 16, 2001
Approved by Governing Board:	February 27, 2001
Amended by Medical Staff:	May 24, 2001
Approved by Governing Board:	June 26, 2001
Amended by Medical Staff:	November 29, 2001
Approved by Governing Board:	December 18, 2001
Amended by Medical Staff:	May 30, 2002
Approved by Governing Board:	June 25, 2002
Amended by Medical Staff:	November 21, 2002
Approved by Governing Board:	January 28, 2003
Amended by Medical Staff:	August 28, 2002
Approved by Governing Board:	September 23, 2003
Amended by Medical Staff:	May 17, 2004
Approved by Governing Board:	May 25, 2004
Amended by Medical Staff:	May 26, 2005
Approved by Governing Board:	June 28, 2005
Amended by Medical Staff:	May 25, 2006
Approved by Governing Board:	June 27, 2006
Amended by Medical Staff:	September 15, 2006
Approved by Governing Board:	September 26, 2006
Amended by Medical Staff:	August 30, 2007
Approved by Governing Board:	September 20, 2007
Amended by Medical Staff:	December 12, 2007
Approved by Governing Board:	December 18, 2007
Amended by Medical Staff:	August 14, 2008
Approved by Governing Board:	August 29, 2008
Amended by Medical Staff:	January 19, 2009
Approved by Governing Board:	January 27, 2009
Amended by Medical Staff:	June 4, 2009

Approved by Governing Board:	June 30, 2009
Amended by Medical Staff:	August 27, 2009
Approved by Governing Board:	September 22, 2009
Amended by Medical Staff:	March 22, 2010
Approved by Governing Board:	March 23, 2010
Amended by Medical Staff:	November 18, 2010
Approved by Governing Board:	November 23, 2010
Amended by Medical Staff:	June 21, 2011
Amended by Governing Board:	June 28, 2011
Amended by Medical Staff:	August 25, 2011
Amended by Governing Board:	October 25, 2011
Amended by Medical Staff:	May 24, 2012
Approved by Governing Board:	June 26, 2012
Approved by Medical Staff:	May 23, 2013
Amended by Governing Board:	May 28, 2013