MEDICAL STAFF BYLAWS
OF
COASTAL CAROLINA HOSPITAL

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ARTICLE 1

NAME

The name of this organization shall be the Medical Staff of **Coastal Carolina Hospital**.

ARTICLE 2

PURPOSE

The purpose of the organization shall be to:

2.1 Give voice to the Medical Staff, the fundamental role of which is to provide care, treatment and services to patients; provide oversight for the quality of care, treatment and services rendered to patients at the Hospital by Practitioners and other Professionals; exercise responsibility for the ongoing evaluation of the competency of Practitioners and other Professionals who have Privileges; and delineate the scope of Privileges to be granted, and provide for safe and uniform quality of patient care. In this regard:

2.1.1 A Physician with appropriate Clinical Privileges shall be responsible for coordinating and managing a patient's care, treatment and services, it being understood that Dentists and Podiatrists shall manage and coordinate specific issues within their scope of practice, competence and privileges;

2.1.2 All Professionals and staff involved in a patient's care shall endeavor to communicate effectively with one another for the benefit of the patient and the safe delivery of quality care.

2.1.3 A Physician shall be on duty or on call at the Hospital at all times.

2.2 Establish a structure for and the rules of self-governance of the Medical Staff; and

2.3 Provide a mechanism for effective communication and resolution of disputes between and among the Medical Staff, Hospital administration and the Governing Board.

ARTICLE 3

THE FUNDAMENTAL ELEMENTS OF SELF-GOVERNANCE

In accordance with the purposes of the organization and recognizing that the Medical Staff is accountable to the Governing Board, the Medical Staff acknowledges:

3.1 The Elements of Self-Governance.

The fundamental elements of self-governance are to:

3.1.1 Establish the standards for Medical Staff membership and Clinical Privileges and provide for means to enforce them.

3.1.2 Identify the mechanism and criteria to be used to conduct Peer Review activity consistent with accreditation requirements, state law, and participation in government funded health care programs, all subject to the approval of the Board.

3.1.3 Establish a process for the selection and removal of Medical Staff officers.

3.1.4 Provide a process for adopting and implementing Governance Documents.

3.1.5 Promote an educational environment conducive to the maintenance of scientific standards and the advancement of professional knowledge and skill.

3.2 The Nature of the Bylaws.

The Bylaws do not constitute a contract but do establish a system of rights, responsibilities and accountability between the Hospital and the Medical Staff.

3.3 The Authority of the Governing Board.

The Governing Board has the ultimate authority and responsibility for the conduct and performance of the Hospital as an institution and for the oversight and quality of care, treatment and services provided.

ARTICLE 4

DEFINITIONS APPLICABLE TO ALL GOVERNANCE DOCUMENTS

Throughout these Bylaws, the following definitions apply to the identified terms whether or not the terms are capitalized, plural, singular, masculine, or feminine, unless the context of the applicable provision indicates otherwise.

4.1 Admitting Privileges: the right to admit patients to the Hospital.

4.2 Advanced Practice Practitioners: includes the following categories of licensed individuals: Nurse Practitioners, Advanced Practice Registered Nurses, Physician Assistants, Certified Registered Nurse Anesthetists, Certified Nurse Midwives and Psychologists.

4.3 Allied Health Professional ("AHP"): a licensed individual, other than a licensed Physician, Dentist, or Podiatrist, permitted to apply for and perform specified procedures and services at the Hospital. The term includes, but is not limited to, Advanced Practice Practitioners. All Allied Health Professionals who provide a medical level of care (*i.e.,* care that involves making medical diagnosis and medical treatment decisions) must be credentialed and granted permission by the Medical Staff and the Board, even if employed by the Hospital.

4.4 Attending Physician: the Physician of record for a patient admitted to the Hospital on an inpatient or outpatient basis.

4.5 Board Certification: certification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Foot and Ankle Surgery (ABFAS), the American Board of Podiatric Orthopaedics and Primary Podiatric Medicine (ABPOPPM) or the National Board of Physicians and Surgeons (NBPAS), unless otherwise approved by the Governing Board.

4.6 Bylaws: The bylaws of the Medical Staff of the Hospital.

4.7 Chief Executive Officer ("CEO"): the individual responsible for overall management of the Hospital.

4.8 Chief Medical Officer ("CMO"): the Physician employed by the Hospital to act as a liaison between the Hospital and the Medical Staff. Responsibilities may be clinical or administrative in nature or both.

4.9 Chief of Staff: a member of the active Medical Staff who is elected in accordance with the Bylaws to serve as the leader of the Medical Staff and to function as the Medical Staff's liaison with Hospital administration and the Governing Board.

4.10 Clinical Privilege/Privileges: permission to perform specified diagnostic and therapeutic services on recommendation of the Medical Staff and approval of the Governing Board.

4.11 Days: calendar days unless otherwise expressly provided.

4.12 Dentist: a person who holds the degree of Doctor of Medical Dentistry or Doctor of Dental Surgery.

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

4.14 Department Chair: the chief of a Department selected in accordance with the Bylaws.

4.15 Disruptive Behavior: personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively. The term includes, but is not limited to, conduct that interferes with one's ability to work with other members of the health care team. Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

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

4.17 Focused Professional Practice Evaluation ("FPPE"): the process by which the Medical Staff will evaluate the privilege-specific competence of a Practitioner. An FPPE: (i) shall be conducted with respect to all provisional staff members and when new privileges are granted; and (ii) may be conducted when a) clinical activity is insufficient to evaluate a Practitioner's ongoing professional competence; or b) when there is a particular question as to a Practitioner's clinical competence. Information obtained from the focused review process shall be used to determine whether to advance a Practitioner from provisional to full status or to grant, modify, restrict, terminate or revoke Clinical Privileges. Information for FPPEs may be obtained from chart review, monitoring clinical practical patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of a patient (e.g., consulting physicians, assistants at surgery, nursing, or administrative personnel). An FPPE may result in but is not itself disciplinary action. The process for conducting FPPEs shall be set forth in the Rules and Regulations or in the form of a policy.

4.18 Good Standing: a Medical Staff Member who, at the time the issue is raised, has not been the subject of a restriction of membership or Privileges in the previous twelve (12) months.

4.19 Governance Documents: documents that establish the requirements for and govern the conduct of Members of the Medical Staff and AHPs. Governance Documents shall include the Bylaws and Medical Staff and Rules and Regulations, which are subject to the joint approval of the Medical Staff and the Board. The term "Governance Documents" also includes policies approved by the Medical Executive Committee to implement the processes described in the Bylaws and Rules and Regulations where further guidance is indicated for clarity or efficiency of administration. Policies may include the Focused Professional Practice Evaluation Policy, Ongoing Professional Practice Evaluation Policy, Code of Conduct, and such other policies as may be approved by the MEC from time to time.

4.20 Governing Board ("Board"): the governing body of the Hospital.

4.21 Harassment: includes, without limitation, i) unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature when: (1) submission to the conduct is made either explicitly or implicitly a term or condition of employment or advancement; or (2) submission to or rejection of such conduct is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment or exercise of Clinical Privileges or performance of specified procedures; or ii) conduct that has the purpose or effect of unreasonably interfering with another

individual's work performance, or creating an intimidating, hostile, or offensive work environment.

4.22 Hospital: Coastal Carolina Hospital.

4.23 Hospital-Based Practitioners: Physicians who hold Clinical Privileges in Emergency Medicine, Radiology, Pathology, Anesthesiology or other specialties pursuant to a contractual arrangement with the Hospital.

4.24 Investigation: a formal, targeted process initiated by the MEC that concerns the professional competence and/or professional conduct of a Practitioner and is generally a precursor to a professional review action or disciplinary action against a Medical Staff Member. Once initiated, the investigation will be considered to be ongoing until the disciplinary process runs its course or until the MEC or the Hospital formally closes the investigation. The term does not include activity conducted by the Practitioner Health Committee nor does it include an Ongoing Professional Practice Evaluation or Review. The MEC will notify a Practitioner in writing when he or she is under investigation.

4.25 Medical Executive Committee ("MEC"): the executive committee of the Medical Staff which shall constitute the leadership of the Medical Staff as described in these Bylaws.

4.26 Medical Review Committee ("MRC"): the committee appointed pursuant to these Bylaws for the purpose of evaluating the evidence and making proposed findings and conclusions in the fair hearing process.

4.27 Medical Staff/Staff/Organized Medical Staff: the formal organization of Physicians, Podiatrists and Dentists who may practice independently and who have been appointed to the Medical Staff pursuant to these Bylaws.

4.28 Medical Staff Services: the administrative office of the Hospital tasked with assisting the Medical Staff to carry out the objectives of these Bylaws and other Governance Documents.

4.29 Medical Staff Year: the calendar year.

4.30 Member: a Practitioner who has been granted and maintains Medical Staff membership and (except for honorary staff) Clinical Privileges and who is in Good Standing pursuant to these Bylaws.

4.31 National Practitioner Data Bank ("NPDB"): National Practitioner Data Bank.

4.32 Ongoing Professional Practice Evaluation ("OPPE"): the process by which the Medical Staff monitors professional practices to identify trends that may affect quality of care or patient safety or require intervention. The types of data to be collected, the mechanisms for acquiring the data or selecting the cases, and the frequency within which the data shall be collected and assessed shall be established by the Medical Staff upon recommendation of and for each Department, consistent with these Bylaws, Rules and Regulations and applicable policy. Information obtained from the OPPE process shall be used to evaluate each Practitioner's professional practice and shall be factored into the decision to maintain existing Privilege(s), to revise existing Privilege(s), or to revoke or restrict an existing Privilege prior to or at the time of renewal. OPPE itself shall not be considered to be disciplinary in nature nor constitute an investigation for purposes of the disciplinary process.

4.33 Oral Surgeon: a Dentist who has received additional training in oral surgery and is certified as such by a generally recognized professional society approved by the Governing Board. Physician member rights apply.

4.34 Peer Review: the various processes by which the Medical Staff conducts critical self-analysis for the purpose of monitoring professional performance, evaluating clinical competence, assessing quality and safety of care, undertaking disciplinary action and improving the quality of patient care. The term encompasses credentialing activity, Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, quality assurance, performance improvement, utilization review and disciplinary action.

4.35 Physician: an individual who holds a current, unrestricted license as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) in this State. Includes Oral Surgeons.

4.36 Podiatrist: an individual who has a doctor of podiatric medicine or surgery degree and a current, unrestricted license to practice podiatry in this State.

4.37 Practitioner: a Physician, Podiatrist or Dentist, who is applying for Medical Staff membership and/or Clinical Privileges or who is a Medical Staff member and/or who exercises Clinical Privileges in this Hospital.

4.38 Proctor: a Practitioner with Clinical Privileges who is engaged in monitoring or evaluating the professional services of another Practitioner and who is in the same or similar specialty as the Practitioner whose performance is being monitored. Allied Health Professionals are subject to monitoring by Practitioners or other AHPs in the same or similar practice area.

4.39 Professional: the term includes both Practitioners and Allied Health Professionals.

4.40 Prompt: five business days, unless otherwise expressly provided in these Bylaws.

4.41 Review: a preliminary fact-finding process that may be initiated by a committee or a Department to determine if an Investigation concerning a Practitioner's professional competence or conduct is warranted.

4.42 Rules and Regulations: the Medical Staff Rules and Regulations.

4.43 State: South Carolina.

ARTICLE 5

CONDITIONS OF APPOINTMENT TO THE MEDICAL STAFF AND EXERCISE OF CLINICAL PRIVILEGES

Appointment to the Medical Staff and exercise of Clinical Privileges shall be conditioned upon the following:

5.1 A Practitioner shall continually meet the qualifications, requirements and duties of the Medical Staff set forth in the Bylaws, Rules and Regulations and other Governance Documents.

5.2 A Practitioner may only provide services to a patient if the Practitioner is a member of the Medical Staff with Clinical Privileges inclusive of the services or if the Practitioner has been granted temporary, disaster or emergency Privileges.

5.3 Practitioners may practice only within the scope of Privileges awarded.

5.4 There shall not be discrimination based on race, religion, color, age, gender, national origin, disability, veteran status, or sexual orientation.

5.5 There shall be no right to Medical Staff Membership or Clinical Privileges based solely on other affiliation.

5.6 The duration of appointment shall not exceed three years.

5.7 A Practitioner who is under contract with the Hospital to provide administrative services but who is also to perform clinical services pursuant to such contract shall be required to qualify for Medical Staff membership and have the pertinent Clinical Privileges. If the contract provides for the physician to relinquish his Clinical Privileges and Medical Staff membership upon termination or expiration of the agreement, fair hearing rights under Article 11 shall be deemed to have been waived and shall not apply.

5.8 All Practitioners and AHPs (collectively “Professionals”) shall adhere to a code of conduct that reflects the following principles (“Code of Conduct”).

5.8.1 All Professionals shall demonstrate courtesy and respect for one another, for patients and for the Hospital in their daily interactions.

5.8.2 All Professionals shall observe professional etiquette when utilizing the telephone and electronic messaging. This includes clear communication, prompt response time to the extent practicable and limiting communication to that reasonable, necessary and appropriate for quality patient care.

5.8.3 All Professionals shall pay attention to the language they use and the intonation of their voice. Profane language, yelling and condescending language or voice intonation are not acceptable and may be considered disruptive behavior.

5.8.4 All Professionals shall follow proper administrative channels to log complaints about the quality of care provided.

ARTICLE 6

REQUIREMENTS FOR MEMBERSHIP

6.1 Eligibility for Application – Exclusion Criteria

No person shall be eligible to receive an initial application for appointment to the Medical Staff who:

6.1.1 Does not have a current and unrestricted license to practice medicine in the State. For purposes of this subsection, the term "restriction" means any limitation of any type whatsoever and encompasses probation. A reprimand or private censure is not a restriction unless applicable state law so provides;

6.1.2 Has a record of revocation, suspension or probation of any medical license in any jurisdiction within the past 10 years, except for administrative reasons unrelated to crimes or professional competence or conduct;

6.1.3 Has a history of conviction or deferred adjudication for a felony crime against a person or who within the immediate past 7 years was (1) convicted or had a deferred conviction for any felony; or (2) was convicted or had a deferred adjudication for any misdemeanor offense related to (i) the practice of medicine; (ii) other healthcare matters; (iii) third party reimbursement; (iv) violence; or (v) the use, prescription, distribution or furnishing of DEA Schedule I – V substances;

6.1.4 Has had his medical staff appointment or clinical privilege at this or any other health care facility denied, revoked, or terminated or who involuntarily relinquished his medical staff appointment or clinical privileges in the same or similar area of practice for reasons related to professional competence or conduct;

6.1.5 Has a record of having been excluded, debarred or otherwise been the subject of adverse legal action taken by a state or federal agency in relation to participation in a federal or state health care program. For purposes of this subsection, the term "adverse legal action" means a Medicare or Medicaid imposed revocation of billing privileges, revocation or suspension by an accreditation organization; or exclusion or debarment from participation in a Federal or State health care program;

6.1.6 Does not have all state and federal controlled substance certificates, including DEA permits, required for medical staff membership or exercise of the Privileges generally awarded in the applicant's specialty;

6.1.7 Has not successfully completed a medical residency accredited by those bodies designated by the Hospital's Governing Board or who does not demonstrate current enrollment in good standing in such a program;

6.1.8 Does not meet the board certification requirements set forth in these Bylaws.

6.1.9 Does not provide proof of professional liability coverage with a qualified carrier of the type and in the amount required by the Board that covers all Privileges that would be requested;

6.1.10 Seeks to obtain Privileges that are subject to an exclusive contractual arrangement or the Department to which the applicant would be assigned is closed;

6.1.11 Does not provide proof of having a primary residence or office located within 30 minutes to be able to render continuous care to patients, excluding consulting staff and telemedicine staff; and

6.1.12 Does not authorize the Medical Executive Committee or other committee engaged in Peer Review activity to receive reports of good standing and professional performance from prior employers and facilities at which he provided professional services and to conduct criminal background checks.

6.2 General Requirements.

To obtain and maintain Medical Staff membership and Privileges, a Practitioner shall continually demonstrate and be able to document the following requirements for membership:

6.2.1 Current competence in general areas:

(a) Patient care (reflecting the expectation that the care will be compassionate, appropriate and effective according to circumstance);

(b) Medical/Clinical Knowledge (reflecting the expectation that Practitioners will demonstrate appropriate levels of knowledge and the ability to apply the knowledge for the benefit of patients);

(c) Practice Based Learning (reflecting the expectation that Practitioners will use scientific methods and rely on evidence to investigate, evaluate and improve patient care);

(d) Interpersonal and communication skills (reflecting the expectation that Practitioners will demonstrate interpersonal and communication skills that foster professional and courteous relationships with colleagues, the care giver team and patients) ;

(e) Professionalism (reflecting the expectation that Practitioners will conduct themselves professionally, ethically and responsibly and will demonstrate understanding and sensitivity to diversity); and

(f) Systems-based practice (reflecting the expectation that Practitioners will make an effort to understand hospital systems, e.g., electronic medical record and ordering systems, and make a reasonable effort to work with them).

6.2.2 Appropriate training and experience for the Clinical Privileges sought.

6.2.3 Board certification within five (5) years of joining the Medical Staff and maintaining such certification in good standing while exercising Privileges at the Hospital. Recertification shall be required in accordance with the rules of the applicable certification board. If the practitioner's board certification lapses or terminates for any reason, the practitioner will have three (3) years to regain certification in that specialty. Failure to regain certification will result in voluntary resignation.

6.2.4 The delivery of professional services in a manner that meets generally recognized standards of care.

6.2.5 Collegial and professional conduct with other members of the health care team consistent with the Code of Conduct.

6.2.6 There is no physical or mental condition that interferes with the Practitioner's ability to provide quality, safe care to patients and to exercise the Clinical Privileges requested with or without reasonable accommodation. To fulfill this obligation, the Practitioner will submit to and pay for a physical, mental, and/or psychological examination upon the MEC's request and by a Professional approved by the MEC.

6.2.7 Appropriate arrangements for coverage of his patients when the Practitioner is not available.

6.2.8 Participation in and cooperation with Peer Review activity, including serving as a Proctor when requested and maintaining the confidentiality of Peer Review proceedings.

6.2.9 Compliance with state and federal requirements regarding billing for professional services.

6.2.10 Preparation and completion of medical records and other documentation so that they are timely, legible, dated, timed, complete and accurate.

6.2.11 Compliance with requirements for conducting a medical history and physical examination ("H&P") as specified here and in the Rules and Regulations:

(a) An H&P shall be completed and documented in the medical record for each patient no more than 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. A Physician shall be responsible for completing and documenting the H&P except that Dentists and Podiatrists shall complete and document those portions of the H&P that are relevant to their practice. An Allied Health Professional is authorized to complete and document the H&P as delineated in the scope of practice extended; however, an H&P documented by an Allied Health Professional shall be countersigned by the Attending Physician within the timeframe prescribed for completion of the H&P by the Medical Staff. In the event of an emergency when it is not feasible to perform a history and physical prior to surgery, the surgeon must complete a brief admission note on the chart. This should include pulmonary status, cardiovascular status, heart rate, respiratory rate and blood pressure.

(b) An H&P performed no more than 30 days before admission or registration may be utilized as the admitting H&P if an update examination, including any changes in the patient's condition, is conducted and documented in the medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. A Physician shall be responsible for completing and documenting the update examination except that Dentists and Podiatrists shall complete those portions of the update examination as are relevant to their practice. An Allied Health Professional is

authorized to perform and document the update examination as delineated in the scope of practice extended; however, the update exam documented by an Allied Health Professional shall be countersigned by the Attending Physician.

(c) The content of all H&Ps shall be in accordance with the requirements set forth in the Rules and Regulations.

6.2.12 Timely and complete responses to inquiries regarding documentation from any Hospital Department or Medical Staff committee, generally within 1 business day of the request.

6.2.13 Providing and seeking consultations in accordance with the procedures set forth in the Rules and Regulations.

6.2.14 Coordination of care, treatment and services among Practitioners involved in the care of a patient in accordance with guidelines set forth in the Rules and Regulations.

6.2.15 The attempt to secure permission for elective autopsy in cases of unusual death and of medical legal and educational interest in accordance with the procedures specified in the Rules and Regulations. Documentation of permission to perform an autopsy shall be on a form approved by the Medical Executive Committee. The Attending Physician shall be informed when an autopsy is being performed.

6.2.16 Prompt notification to the CEO in the event of any change in or loss of professional liability insurance coverage, including tail coverage, generally within 1 business day of notice of the change in or loss of coverage.

6.2.17 Compliance with Bylaws, Rules and Regulations, and applicable Governance Documents.

6.2.18 Compliance with patient privacy policies as set forth in the Rules and Regulations and other policies and procedures governing the Medical Staff.

6.2.19 Timely completion of continuing medical education requirements as necessary for licensure or as established by the Board following consultation with the Medical Staff.

6.2.20 Participation in training as required by the Hospital with regard to computer training, privacy practices and medical record training.

6.2.21 Participation in emergency coverage for the Emergency Department as prescribed by the Board following consultation with the MEC.

6.3 Harassment.

Harassment based on gender, race, religion, color, ancestry, age, disability, marital status and sexual orientation is prohibited. Allegations of harassment shall be investigated by the Medical Executive Committee and, if confirmed, will result in disciplinary action.

6.4 Notification of Adverse Action.

Each Practitioner shall promptly notify the CEO in the event of i) an adverse license action in any jurisdiction; ii) an adverse credentialing action at any hospital; iii) exclusion from the Medicare, Medicaid, Tricare or any government-funded health care program; iv) the conviction of any felony or a misdemeanor; v) the filing or service of any professional liability demand letter or lawsuit; or vi) the settlement of or judgment in any malpractice action regardless of the amount; vii) voluntary surrender of privileges with any health care facility during an investigation or in order to avoid an investigation; or viii) entry into an order with any licensing board whether public, non-public, disciplinary or non-disciplinary.

In addition, a Practitioner shall promptly notify the CEO of i) the initiation of informal or formal action against the Practitioner relating to the treatment of a patient, professional conduct, or professional competence of the Practitioner by any professional licensing board, the U.S. Drug Enforcement Administration, the U.S. Food and Drug Administration, Medicare, Medicaid, Tricare or any government–funded health care program; and ii) notice of an investigation by any licensing board, federal or state health regulatory agency or Medicare/Medicaid/Tricare or government-funded health care program for matters relating to the Practitioner's professional competence, professional conduct or billing practices.

6.5 Waiver of Requirements for Medical Staff Membership or Privileges.

A requirement for Medical Staff membership or Privileges may be waived by the Board upon request of the MEC upon determination that waiver in a particular instance is in the best interest of patients and the Hospital. Waivers shall be the exception and shall be undertaken rarely.

6.6 Closed Staff; Exclusive Arrangements for Professional Services.

The Board may determine as a matter of policy that certain Hospital clinical facilities or Departments may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified professionals. These may include, but are not limited to, hospital-based services such as Emergency Medicine, Radiology, Pathology, Anesthesiology or other specialties. A Practitioner who is to provide professional services at the Hospital pursuant to an exclusive contract arrangement shall be processed for appointment, reappointment and Clinical Privileges in the same manner and shall fulfill all of the obligations for membership category and Clinical Privileges as any other applicant or member. Practice at the Hospital shall, however, be contingent upon continued qualification for membership and Clinical Privileges and the terms of the exclusive services arrangement. Notwithstanding anything to the contrary in these Bylaws, a Member shall have none of the rights set forth in Article 11 of these Bylaws in the event of termination of practice at the Hospital due to termination of association with the contracting medical practice, the Hospital's request that the contracting practice not assign the Member to deliver services under the contract or the Hospital's decision to terminate the applicable contract for any reason. Further, no Practitioner shall have a right to hearing pursuant to Article 11 due to rejection of a request for membership or Clinical Privileges which have been granted on an exclusive basis to another Practitioner or group of Practitioners.

ARTICLE 7

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

7.1 Terms of Appointment.

Every applicant for appointment and reappointment shall

7.1.1 Be subject to the Credentialing Procedures set forth in the Rules and Regulations.

7.1.2 Submit a completed application. Completed means an application for appointment, reappointment, and/or the grant of clinical privilege that requires no follow-up because (i) the applicant has answered all questions and provided all requested documentation and verifications and (ii) the Medical Staff Services received all other necessary documentation and verifications solicited by the Hospital. No application shall be considered to be complete until the applicable Department Chair and the MEC have each reviewed the application and determined that no further documentation or information is required to permit consideration and evaluation of the application.

7.1.3 Notify the Chief of Staff promptly if information contained in the application has changed since submission of the application.

7.1.4 Submit peer references as required in the Credentialing Procedures. Peer references shall describe current competence in general areas.

7.1.5 Authorize the Hospital to conduct a criminal background check.

7.1.6 Authorize the Hospital to communicate with other hospitals with which the applicant has been associated or who may have knowledge about the applicant regarding the applicant's professional conduct and competence.

7.1.7 Authorize the release of all relevant documents and information.

7.1.8 Submit information about any action or investigation relating to professional conduct or competence undertaken by any licensing agency, hospital, professional society, third party payer or with respect to any legal claim or complaint brought against the Practitioner relating to professional competence or conduct.

7.1.9 Secure and maintain at all times appropriate and current professional liability (medical malpractice) insurance coverage, with a viable insurer acceptable to Hospital, with no gaps occurring at any time during the Physician's practice of medicine in the State, at limits established by the Governing Board from time to time. If such professional liability coverage is at any time claims-made and coverage is canceled or non-renewed for any reason, the Practitioner shall notify the Medical Staff Services office promptly and either: 1) purchase extended reporting coverage ("tail coverage") for all claims arising out of the incidents occurring prior to the cancellation/non-renewal of said policy; or 2) purchase prior acts coverage for the subsequent policy with a retroactive date no later than the effective date of the original, cancelled/non-renewed policy. Copies of certificates of insurance shall be provided to the Hospital promptly upon request.

7.1.10 Document that no physical or mental health issue exists that would interfere with the exercise of the Clinical Privileges requested.

7.1.11 Submit information relating to the voluntary or involuntary resignation from any hospital or restriction of privileges, and notify the Hospital if the Practitioner fails to appeal any corrective action or disciplinary action at any other facility.

7.1.12 Acknowledge that he has read the Bylaws and Rules and Regulations and agrees to abide by them as well as with applicable policies.

7.1.13 Release and hold harmless from liability the Hospital and all individuals engaged in Peer Review activity, including credentialing activity, that is conducted in good faith.

7.1.14 Agree to participate and appear for interviews upon request of medical staff officers and Department Chairs, committee chairmen and hospital CEO, CNO or CMO

7.1.15 Provide a current picture hospital ID card or a valid picture ID issued by a state or federal agency to permit verification of identity.

7.1.16 Upon the MEC's request, sign a special release and authorization affirming some or all of the terms listed in Section 7.1.

7.2 Burden on Applicant.

The burden shall be on the applicant to complete the application, to provide the information requested in a timely and accurate manner, and to demonstrate that he or she meets all requirements for the privileges requested. The applicant shall have the burden of removing any doubt. A Practitioner's failure to submit correct information in the timeframes requested or the submission of misleading information may result in the application being deemed incomplete or to have been withdrawn. An application that is returned because it has been deemed withdrawn shall not be considered a determination based on the conduct or competence of the Practitioner, and the return of the application shall not give rise to hearing and appeal rights under these Bylaws.

7.3 Pre-Application Process

7.3.1 The MEC shall implement a pre-application process that requires individuals to submit a pre-application form as a part of any request for initial Medical Staff membership or Clinical Privileges. The pre-application form shall require that potential applicants provide information and documents that demonstrate the individual meets both (i) the criteria specified in the Bylaws to be eligible to be considered for initial Medical Staff membership or Allied Health Professional status, and (ii) the applicable criteria established by the Medical Staff to be eligible to apply for Clinical Privileges in the individual's proposed area of practice. No application for appointment and/or Clinical Privileges will be provided to a potential applicant, nor will an application be accepted from a potential applicant until the pre-application process confirms that the individual is eligible to apply for membership and eligible to apply for the applicable Clinical Privileges in the individual's proposed area of practice.

7.3.2 The MEC may designate an agent to process the pre-application on behalf of the Medical Staff, such agent to provide the results of the processing to the MEC, including all of the information and documents collected.

7.3.3 If review of the pre-application form demonstrates the individual meets the criteria to receive an application, the Medical Staff Services office shall provide the individual with an application for appointment and/or Clinical Privileges.

7.3.4 If an individual does not meet both the criteria to be eligible to (i) be considered for membership, and (ii) apply for Clinical Privileges in the individual's proposed area of practice, the individual is not entitled to an application for appointment and is not entitled to a Medical Staff hearing or other appellate review process set forth in these Bylaws. The individual will be notified of the criteria not satisfied. The individual shall be deemed to have accepted such determination, unless the individual, within thirty (30) days of the date of the notification, submits to the MEC documentation that demonstrates that the individual meets the criteria to receive an application. The decision of the MEC shall be final. A person who is refused an application because he is determined ineligible to receive one shall be deemed to have been declined an application for lack of eligibility and not denied appointment for reasons relating to professional competence or conduct.

7.3.5 The MEC may establish administrative procedures to implement the pre-application process, such as pre-application fees, requirements for timely completing the pre-application process, and requirements for timely submitting an application for appointment if the Medical Staff provides the application for appointment.

7.3.6 The completed pre-application form and the information and documents collected as part of the pre-application process shall be considered and maintained as Peer Review documents in the manner prescribed in these Bylaws and shall not be retained in any administrative files nor used for any purposes other than Peer Review.

7.4 Initial Application Process.

The process for review of an initial application shall be as follows:

7.4.1 Initial review by the office of Medical Staff Services for completeness, primary verification of current license, relevant training and clinical competence, collection of external data relating to application (including peer recommendations regarding the Practitioner's current competence), initiating and obtaining the results of a criminal background check and querying the NPDB. The office of Medical Staff Services shall also request and collect available peer review information from entities at which the Practitioner currently has Privileges as well as Practitioner-specific information resulting from Peer Review activity at the Hospital, including Focused and Ongoing Professional Practice Evaluations, as outlined in the Rules and Regulations and applicable policies.

7.4.2 Review of the completed application and collected data by the chair of the Department to which the Practitioner would be assigned. The Department Chair shall make a recommendation as to Medical Staff membership and the Clinical Privileges to be awarded.

7.4.3 Review by the MEC. Within sixty (60) days following receipt of the recommendation of the Department Chair, provided that the application is complete, the MEC shall make a recommendation to the Board as to Medical Staff membership and the Clinical Privileges to be awarded. The recommendations may be as follows:

(a) Recommendation for appointment with Clinical Privileges requested.

(b) Recommendation for appointment but with only particular Privileges which are less than all Privileges requested.

(c) Recommendation against appointment.

(d) Rejection of application as incomplete.

7.4.4 If the MEC recommends that an application be denied in whole or in part, there shall be no further action by the Board until the applicant's hearing and appeal rights are exhausted or waived.

7.4.5 The Chief of Staff shall promptly inform the applicant of the recommendation and, if adverse to him, shall give the applicant the reason[s] for the adverse recommendation and inform him or her of available fair hearing rights, and mediation, if required by applicable state statute. Applicants may be reappointed for short periods in order to maintain the status quo during the hearing and appeal process described in these Bylaws, but such reappointment shall not be construed to constitute a positive action with regard to the matter under review.

7.4.6 Action by the Board on the application and recommendation. Within sixty (60) days following receipt of the MEC recommendation, provided that the application is complete, the Governing Board of the Hospital shall take final action on the application for Medical Staff membership and Clinical Privileges. The applicant shall be given prompt notice of the Board's determination and the reasons therefore if the determination is adverse to the applicant. The Hospital will notify the applicant in writing of the Hospital's final action within twenty (20) days after the date on which final action is taken.

7.4.7 The CEO shall report adverse determinations to the NPDB and state licensing agencies as required by law.

7.5 Reappointment.

7.5.1 Each Practitioner shall be sent 120 days advance notice that his term of appointment is expiring and that he must complete and submit an application for reappointment within the time frames prescribed. A Practitioner who does not submit an application for reappointment within the time frames prescribed in the Rules and Regulations shall be deemed to have resigned from the Medical Staff.

7.5.2 Applications for reappointment shall be processed and considered in the same manner as for applications for appointment.

7.5.3 Information obtained from Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations as well as other Peer Review

activity shall be factored into the determination to grant, deny, or modify the application for reappointment.

7.5.4 Where there has been a lack of activity, the MEC may recommend monitoring in the form of proctoring or other forms of FPPEs such as retrospective record review.

7.6 Leave of Absence.

A Practitioner may request a leave of absence for a period not to exceed one year by submitting a request to the Medical Executive Committee with a copy to the Chief of Staff stating the purpose and period of time for the leave of absence. A staff member shall not be entitled to exercise Clinical Privileges at the Hospital during the leave of absence. The leave of absence may be extended upon written request for an additional period of up to one year, but in no case shall the leave of absence extend beyond the term of appointment. Liability insurance, including tail coverage, must be maintained during the leave of absence unless waived for good cause upon recommendation of the MEC and approval by the Board.

At least thirty days prior to expiration of the leave of absence or at any earlier time, the Practitioner may request reinstatement of his Clinical Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Practitioner shall submit a written summary of his relevant activities during the leave. If the leave was requested for personal health reasons, the Practitioner shall submit documentation from a licensed physician acceptable to the MEC, verifying that no health problems exist that would interfere with the Practitioner's ability to perform the Clinical Privileges requested. The Medical Executive Committee shall make a recommendation to the Board. Thereafter, the procedures provided for consideration of an application for reappointment shall be followed. Practitioners returning to clinical practice at the Hospital following a leave of absence in excess of one year shall be subject to a Focused Professional Practice Evaluation.

Failure to request reinstatement or to provide a summary of activities or verification of health status shall be deemed a voluntary resignation from the Medical Staff and fair hearing/appeal rights shall not apply. A request for Medical Staff membership and Clinical Privileges subsequently received from the Practitioner shall be submitted and processed as in the case of a new application.

7.7 Maintenance of Peer Review Materials.

The Medical Staff Services office shall maintain Peer Review documents that relate to individual Practitioners.

Peer Review documents shall be maintained in a manner that will preserve the confidentiality of the documents to the maximum extent permitted by law. A Practitioner's application for Medical Staff membership and Clinical Privileges and information obtained from public entities shall be segregated from evaluative materials acquired or generated in the course of Peer Review activity. The latter include, but are not limited to, letters of reference, proctoring forms, and committee minutes that reflect Peer Review activity or that contain Peer Review information.

ARTICLE 8

CATEGORIES OF THE MEDICAL STAFF

8.1 Active Medical Staff.

8.1.1 Obligations of the Active Medical Staff

A member of the Active Medical Staff shall have the duty to:

(a) Meet all requirements for Medical Staff Membership

(b) Participate in Peer Review activity as requested

(c) Engage in at least 12 clinical encounters per 12-month period. A clinical encounter means an admission or consultation**.**

(d) Participate in the on-call roster for the Emergency Department as required by the Board

(e) Pay dues

8.1.2 Prerogatives of the Active Medical Staff

A member of the Active Medical Staff shall have the right to:

(a) Admit and attend patients

(b) Vote

(c) Hold office

(d) Attend meetings

8.1.3 Activity

If a practitioner has less than 12 clinical encounters per 12-month period the practitioner will automatically transfer to Courtesy Staff at the end of the appointment cycle.

8.2 Courtesy Staff.

8.2.1 Obligations of the Courtesy Medical Staff

A member of the Courtesy Medical Staff shall:

(a) Meet all requirements for Medical Staff Membership

(b) Participate in Peer Review activity as requested

(c) Engage in not more than 11 clinical encounters per 12-month period. A clinical encounter means an admission or consultation.

(d) Obtain reports of activity levels and the results of performance monitoring of their practice at other facilities where they are an active member of the Medical Staff.

(e) Not vote

(f) Not hold office

(g) Pay dues

8.2.2 Prerogatives of the Courtesy Medical Staff

A member of the Courtesy Medical Staff:

(a) May admit and attend patients

(b) May attend meetings

8.2.3 Activity

If a practitioner has zero (0) admissions, surgeries, and/or consultations for one (1) reappointment cycle, the practitioner will automatically transfer to Affiliate Staff at the end of the appointment cycle.

8.3 Consulting Staff.

8.3.1 Obligations of the Consulting Medical Staff

A member of the Consulting Medical Staff shall:

(a) Meet all requirements for Medical Staff Membership, except for 6.1.11

(b) Are a special category of physicians each of whom, by virtue of Board Certification, training and experience, is recognized by the medical community as an authority within his/her specialty

(c) Provide hands-on care of a hospital patient in those situations where the consulting Staff member's expertise is required and the consulting Staff member has received a request from an active or courtesy Staff member to provide such care

(d) Participate in Peer Review activity as requested

(e) Not transfer patients from the hospital or be the physician of primary care or responsibility for any patient within the hospital

(f) Not vote

(g) Not hold office

(h) Pay dues

8.3.2 Prerogatives of the Consulting Medical Staff

A member of the Consulting Medical Staff:

(a) May attend meetings

8.4 Affiliate Staff.

The Affiliate Medical Staff is intended for Practitioners who do not admit or treat patients at the Hospital but who request Medical Staff membership for purposes of participating in continuing medical education and meeting the requirements of certain third party payers for hospital affiliation.

8.4.1 Obligations of the Affiliate Staff

A member of the Affiliate Staff shall:

(a) Meet the criteria for membership

(b) Not admit or treat patients at the Hospital

(c) Not vote

(d) Not hold office

8.4.2 Prerogatives of the Affiliate Staff

A member of the Affiliate Staff:

(a) May attend meetings

(b) Participate in continuing medical education sessions

(c) Engage in Peer Review activity

8.5 Honorary Staff.

The Honorary Staff is intended for Practitioners who do not practice at the Hospital but who wish to maintain an affiliation with the Hospital. The Honorary Staff shall consist of distinguished Practitioners and retired members of the Medical Staff in Good Standing. Members of the Honorary Staff:

8.5.1 May receive notices of and attend Medical Staff meetings

8.5.2 May not vote or hold office

8.5.3 May not admit or treat patients at the Hospital.

8.6 Provisional Status for Initial Appointments.

All initial appointments to the Medical Staff in any category shall be provisional. Provisional status shall be for a minimum period of 12 months and may be extended to 24 months. Provisional staff members shall have the same rights and responsibilities as Practitioners in the respective categories who are not provisional. All provisional staff members shall be subjected to Focused Professional Practice Evaluations to determine eligibility for advancement to full status. Failure to qualify for advancement from provisional to full status shall result in

termination of a Practitioner's appointment and shall give rise to hearing and appeal rights in accordance with those Bylaws.

8.7 Focused Professional Practice Evaluation.

All members of the Medical Staff shall be subject to Focused Professional Practice Evaluations under certain circumstances.

8.7.1 Appointment to the Provisional Medical Staff

(a) An FPPE may be accomplished by multiple methods as set forth in the Rules and Regulations or FPPE policy but primarily by direct observation, retrospective medical record review, and discussion with others (collectively "Proctoring").

(b) A Department, in a manner consistent with the Medical Staff-wide FPPE Policy and Rules and Regulations, shall specify the duration of the Proctoring period; identify the number of cases to be proctored; explain how cases to be proctored will be selected; specify the method of Proctoring; establish standards for when review by an external source will be obtained; and design a monitoring work plan for use by the Proctor. External sources shall be consistent with standards approved by the Governing Board and shall not include pharmaceutical or device manufacturers or distributors. The cases to be reviewed by the Proctor should reflect the spectrum of privileges afforded.

(c) Unless external review is utilized, proctoring shall be conducted in an objective manner by a member of the Medical Staff in good standing who shall hold Privileges in the same Section and shall not be a member of the Practitioner's professional practice. The Department Chair shall identify and assign a qualified Proctor. Service as a Proctor is an obligation of Medical Staff membership. The Proctor and the individual to be proctored shall cooperate in scheduling cases to be proctored to minimize inconvenience for the parties.

(d) The Proctor shall submit his summary observations to the Department Chair on the form established for the purpose. A copy of the summary observations shall be provided to the Practitioner and to the Medical Executive Committee.

(e) If the clinical activity of a Practitioner is insufficient to complete proctoring during the provisional period, proctoring may be extended beyond the provisional period for a maximum of 24 months.

(f) A Member shall remain in proctored status until the Department Chair or applicable committee chair determines that proctoring requirements have been fulfilled and submits such notification to the Medical Executive Committee.

(g) A Practitioner shall satisfy the Proctoring requirements imposed in the time required. If he or she does not, Clinical Privileges will be deemed to have been resigned voluntarily and Medical Staff membership will be terminated.

(h) Hearing and appeal rights shall be deemed waived and not be available to a Practitioner if the decision to deny advancement is based on the Practitioner's failure to meet threshold requirements for the grant of

Medical Staff membership and Clinical Privileges such as board certification or minimum patient encounters.

(i) Hearing and appeal rights shall be available if a Practitioner is denied advancement to full status for reasons related to professional competence or conduct.

8.7.2 Other Applications of FPPE

In addition to evaluating the professional practice of a newly appointed member of the Medical Staff, Focused Professional Practice Evaluations shall be utilized whenever:

(a) new privileges are awarded, regardless of whether the Practitioner has already achieved full status as a member of the Medical Staff;

(b) clinical activity is insufficient to evaluate the ongoing clinical performance of a Practitioner; and

(c) questions about an individual Practitioner's judgment or professional competence or conduct arise.

The procedures for implementing FPPE in such instance shall be the same as in the case of appointment to provisional Medical Staff status.

8.7.3 Identification of FPPE as Investigation or Review

The committee or Department imposing the FPPE shall determine and advise the Practitioner regarding whether the FPPE is a Review or Investigation. An FPPE, such as FPPEs for all new members and recipients of new Clinical Privileges, that is routinely used to evaluate the competence of all or an identified group of Practitioners against clearly defined measures is not an Investigation. When an FPPE is implemented to evaluate a specific Practitioner because of questions about that Practitioner's competence or conduct, then the FPPE will likely fall within the definition of Investigation.

8.7.4 Use of FPPE Information

FPPE information and results shall be forwarded to the Department and the Medical Executive Committee and may be utilized:

(a) in the credentialing and recredentialing of a Professional;

(b) in the decision to grant, deny or restrict Clinical Privileges;

(c) in determining whether to initiate or seek disciplinary action; and

(d) for educational purposes.

ARTICLE 9

CLINICAL PRIVILEGES

9.1 Clinical Privileges.

9.1.1 A Practitioner may only exercise the Clinical Privileges granted to him.

9.1.2 Each Department shall delineate the Privileges that may be exercised in the Department and identify the criteria to be used in extending such Privileges.

9.1.3 The determination to grant a request for specific Clinical Privileges shall be based on evidence of current competence and appropriate training. The decision to grant or deny a request for specific Clinical Privileges shall take into account documented results of patient care activity, including Focused Professional Practice Evaluations, Ongoing Professional Practice Evaluations, performance of a sufficient number of procedures to demonstrate and maintain proficiency and, if applicable, reports regarding relevant clinical experience at other Joint Commission-accredited hospitals or ambulatory care facilities.

9.1.4 If privileges are to depend on experience, the application for appointment and privileges shall demonstrate the requisite experience.

9.1.5 Focused Professional Practice Evaluations shall be implemented for all newly awarded privileges.

9.1.6 The mechanism for evaluating and granting new privileges.

(a) A Department shall describe and support with peer reviewed medical literature the new technique or procedure, the training required to perform such technique or procedure competently, and any relevant staffing, space or equipment needed in order for the technique or procedure to be performed at the Hospital.

(b) A Department, after thorough review of all the information obtained, shall develop a privilege checklist or core privilege list that an applicant will be required to submit.

(c) All new Privileges shall be subject to MEC and Board approval prior to being awarded.

(d) When the Hospital determines to acquire new technology, a determination to grant Privileges for use of such technology shall be based on the considerations set forth in subsections (a) through (c) above). Focused Professional Practice Evaluations may be conducted by external review if the necessary expertise is not available from within the ranks of the Medical Staff. Such external review may include observations conducted by qualified representatives from the manufacturer or developer of the technology as permitted by Hospital policy, taking into account considerations of informed consent and applicable privacy laws. The determination as to what constitutes a qualified representative shall be made by the CEO in consultation with the Department Chair and Chief of Staff. The FPPE process for new privileges shall not constitute an investigation.

9.2 Temporary Privileges

9.2.1 General

(a) There is no right to temporary Privileges.

(b) All temporary Privileges shall be granted by the CEO or his designee following recommendation from the Chief of Staff or designee.

(c) No form of Temporary Privileges may be awarded unless the following information from the Practitioner requesting such Privileges has been verified: current competence and license, relevant training or experience, ability to perform the privileges requested, query and evaluation from the NPDB, no previously successful challenge to licensure, no previous adverse action with respect to license or Clinical Privileges.

(d) Temporary Privileges may be awarded in the following categories: interim appointment, visitor and locum tenens.

9.2.2 Interim appointment

The category is intended for a new applicant, whose application is complete, who is otherwise qualified for and for whom the Department Chair has recommended appointment and is awaiting approval by the MEC and Governing Board.

(a) The interim appointment shall not exceed 120 days.

(b) Practitioners holding interim appointments shall be subject to Focused Professional Practice Evaluations as in the case of new privileges.

(c) “New applicant” includes an individual currently holding Privileges who is requesting one or more additional Privileges.

9.2.3 Visitor Temporary Privileges

Visitor temporary privileges may be granted upon written request, when a Practitioner’s expertise is needed or desired for the care of a specific patient. The following rules apply:

(a) The current competence and current licensure of the Practitioner shall be verified and the documentation shall reasonably support the conclusion that there are no issues relating to the Practitioner’s qualifications, ability and judgment.

(b) The Practitioner seeking visitor temporary privileges shall be a member of another Joint Commission-accredited hospital in good standing.

(c) Visitor temporary privileges may be awarded for periods of no more than 5 times in one year.

(d) Practitioners holding visitor temporary privileges shall be subject to FPPEs.

9.2.4 Locum Tenens.

Locum tenens privileges may be granted upon written request to provide professional services for another staff member when such staff member is unavailable and a substitute is required to fulfill an important patient care, treatment, and service need. The following rules apply:

(a) The current competence and current licensure of the Practitioner shall be verified and the documentation shall reasonably support the conclusion that there are no issues relating to qualifications, ability and judgment.

(b) The Practitioner seeking locum tenens privileges shall be a member of another Joint Commission-accredited hospital.

(c) The granting of locum tenens privileges is subject to a maximum of three 60-day locum tenens terms in a consecutive 12-month period.

(d) Practitioners holding locum tenens Privileges shall be subject to focused review as in the case of new applicant.

9.3 Denial of Temporary Privileges.

9.3.1 The grant of temporary privileges may be withdrawn by the Chief of Staff or CEO, after consultation with the Chief of Staff, following receipt of information that reasonably demonstrates a question regarding the Practitioner's training, qualifications, judgment, skill, ability or conduct. Temporary privileges may also be withdrawn if the Chief of Staff, or the CEO, after consultation with the Chief of Staff, determines that the Practitioner does not meet the requirements for the grant of temporary privileges.

9.3.2 The reason for the decision to withdraw temporary privileges shall be communicated to the affected Practitioner in writing and shall be effective immediately.

9.3.3 The withdrawal of temporary privileges shall not be subject to hearing and appeal rights unless the withdrawal is for reasons relating to professional competence or conduct.

9.4 Emergency Privileges.

Emergency Privileges shall be available to a Practitioner to provide such medical services within the scope of his license as may be necessary to protect a patient from imminent danger or serious or permanent harm or death where delay would add to the degree of danger. Emergency privileges shall end as soon as the danger has subsided.

9.5 Disaster Privileges.

Disaster privileges may be granted to an eligible volunteer by the CEO or designee with consultation from the Chief of Staff when: i) the Emergency Management Plan is activated; and ii) the Hospital is unable to meet immediate patient needs. The following rules shall apply:

9.5.1 The person requesting disaster privileges can demonstrate:

(a) A valid government-issued photo ID and

(b) One of the following: current picture Hospital ID card that clearly identifies professional designation, current license to practice, primary source verification of license, identification indicating that the individual is a member of a Disaster Medical Assistance Team or Medical Reserve Corps unit, or has been registered with the Emergency System for Advance Registration of Volunteer Health Professionals; identification indicating that the individual has been granted authority to render patient care, treatment and services in an emergency by a government agency; or confirmation by a current member of the Medical Staff who has personal knowledge about the individual's ability to act as a licensed independent Practitioner during an emergency.

9.5.2 Primary source verification of licensure shall be completed as soon as the disaster is under control or within 72 hours of the Practitioner's arrival, whichever is earlier. If more time is required, verification shall be secured as soon as possible, but the Hospital shall document why the additional time is necessary and provide evidence of the Practitioner's demonstrated ability to continue to provide care.

9.5.3 The Chief of Staff shall arrange for direct observation or clinical record review of each person exercising disaster privileges.

9.5.4 The Hospital shall maintain and keep current a roster of persons authorized to exercise disaster privileges.

9.5.5 The CEO (or his designee), in consultation with the Chief of Staff, shall decide within 72 hours of granting disaster privileges to an eligible volunteer whether such privileges should be continued, and, if so, for how long. The decision shall be based on information available regarding the professional practices of the eligible volunteer.

9.5.6 Disaster privileges shall terminate automatically when the emergency has subsided or when the eligible volunteer's services are no longer required.

9.5.7 A Practitioner whose disaster privileges are suspended for more than thirty (30) days or terminated as a result of corrective action procedures shall be entitled to hearing and appeal rights.

9.6 Modification of Clinical Privileges.

A Practitioner may request modification of his Clinical Privileges. Such request shall be in writing on the Board approved form. A request for new privileges shall be handled in the same manner as for a new applicant.

9.7 Privileges for Dentists and Podiatrists.

9.7.1 All Dentists and Podiatrists shall be subject to the same requirements and procedures for appointment and reappointment to the Medical Staff as any Physician.

9.7.2 A Physician member of the Medical Staff shall admit and assume responsibility for care of the patient's medical problems.

9.7.3 A Dentist or Podiatrist may perform a history and physical relating to his own specialty. Otherwise, the history and physical shall be performed by a Physician member of the Medical Staff.

9.8 Telemedicine Privileges.

9.8.1 Definitions

(a) Distant Site: A Medicare participating, Joint Commission accredited hospital or ambulatory care organization where the Practitioner providing the professional service is located.

(b) Distant Site Practitioner: a Practitioner who is privileged at the Distant Site and provides professional services for a patient at the Originating Site via Telemedicine link.

(c) Originating Site: Site where the patient is located at the time the Telemedicine service is performed. The Hospital shall be considered the Originating Site for purposes of this section.

(d) Telemedicine: Telemedicine means the use of medical information exchanged from one site to another via electronic communications.

(e) Telemedicine Entity: An organization or entity that provides interpretive services via telemedical link to the Hospital through a contractual relationship and that has provided satisfactory contractual assurance to the Hospital that:

1. The entity has a credentialing and privileging process that is consistent with and meets the standards for credentialing and privileging established by the Joint Commission;

2. The entity furnishes services in a manner that permits the Hospital to comply with Medicare Conditions of Participation

3. The entity has provided the Hospital with a current list of the privileges granted to any individual who will provide interpretive services to the Hospital.

9.8.2 The MEC shall recommend which clinical services are appropriately delivered via Telemedicine link and which contracts are eligible for credentialing by proxy following consultation with the relevant Departments. The final delineation of Telemedicine Privileges shall be subject to the recommendation of the MEC and Board approval. In making such recommendation the MEC shall identify and review performance measures, including the result of OPPE.

9.8.3 All Distant Site Practitioners seeking to provide Telemedicine services to Hospital patients shall complete a Request for Application or pre-application to be processed by the originating site pursuant to Article 1, Part C of the Policy on Appointment and Clinical Privileges to determine eligibility.

9.8.4 Once eligibility is determined, all Distant Site Practitioners seeking to provide Telemedicine services to Hospital patients shall furnish a provider profile to include at a minimum, demographic data, malpractice data, hospital affiliations

for the past ten years and all state licensure data. In processing and making a final decision on an application from a Distant Site Practitioner, the Medical Staff and the Board may rely on credentialing information and the privileging decision from a Distant Site as long as:

(a) The Distant Site is a Medicare participating, Joint Commission accredited hospital or an ambulatory care organization that has an agreement with the Hospital to provide certain services via telemedical link;

(b) The Practitioner is privileged at the Distant Site for the services he seeks to provide at the Hospital;

(c) The Distant Site has provided the Hospital with a current list of the Practitioner's privileges at the Distant Site.

9.8.5 Practitioners providing only interpretive services (providing readings of images, tracings or specimens via telemedical link pursuant to a contractual relationship with the Hospital shall be required to apply for Telemedicine Privileges. In this instance the Medical Staff and the Board may accept the credentialing and privileging decision of the Telemedicine Entity when making decisions on Privileges.

9.8.6 All Practitioners exercising Telemedicine Privileges at the Hospital shall be subject to Peer Review activity, including OPPE and FPPE in accordance with these bylaws. In the case of a Distant Site Practitioner the Hospital will arrange for Peer Review information that is useful to assess the Practitioner's quality of care, treatment and services to be sent to the appropriate peer review entity at the Distant Site or, in the case of contracted interpretive services, to the Telemedicine Entity. Such information shall include at a minimum all adverse outcomes related to sentinel events that result from the Telemedicine services provided at the Hospital and complaints about the Distant Site Practitioner or individual providing interpretive services from patients, members of the Medical Staff, and Hospital Staff. All sharing of information between the Hospital and the Distant Site or Telemedicine Entity will be in compliance with state and federal regulations to protect the confidentiality of Peer Review information and patient protected health information.

9.8.7 All individuals exercising Telemedicine Privileges at the Hospital shall:

(a) have a current and unrestricted license to practiced medicine in the State unless State law expressly permits otherwise and the Board so approves;

(b) provide proof of liability insurance and tail coverage in the type, amount and duration required by the Board;

9.8.8 No Practitioner may provide Telemedicine services to a patient without having been granted Clinical Privileges to do so. This includes Practitioners who are providing interpretive services via a telemedicine link.

9.8.9 Practitioners from a Distant Site who are granted Clinical Privileges for Telemedicine or who are providing interpretive services through a contract with a Telemedicine Entity may be excused from requirements in the Governance Documents relating to the geographic location of the practice, coverage of the emergency department, attendance at meetings, documentation of

immunizations(MMR, HepB, PPD, Influenza, Tdap and Varicella), and Annual Physician Education regarding Environment of Care, Restraints, Pain Management, Infection Prevention, Rapid Response, National Patient Safety Goals, and ER Calls and Transfers. Telemedicine practitioners are not required to hold current state controlled substance licensure.

ARTICLE 10

EVALUATION OF MEDICAL STAFF MEMBER CONDUCT OR PERFORMANCE

10.1 Basis and Purpose for Review.

10.1.1 A Review may be undertaken whenever the professional competence or conduct of any Medical Staff Member appears to:

(a) Compromise or may compromise patient care or safety;

(b) Present a question as to the Member's competence, judgment, ethics, qualifications, ability to work cooperatively with others, or physical or mental health;

(c) Violate his obligations as a member of the Medical Staff or any of the duties and responsibilities imposed pursuant to the Governance Documents; or

(d) Act in a manner detrimental to the operations of the Hospital.

10.1.2 A Review is preliminary in nature. A request for Review shall constitute a complaint and may be brought by any person. The Hospital shall develop an internal reporting process to collect complaints concerning a Member's clinical competence or professional conduct. The process shall provide that such complaints will be forwarded to an appropriate Department or committee. Upon receiving a complaint, Departments and committees shall initiate a Review for the purpose of gathering facts and determining if an investigation is necessary. If a Department or a committee determines that an investigation may be necessary, the chair of the Department or committee shall make a written report to the MEC outlining the results of its fact-gathering process and requesting an investigation.

10.2 Mechanism for Initiating an Investigation.

All requests for an investigation shall be submitted to the MEC through the Chief of Staff, and shall set forth the specific conduct constituting the need for the investigation. Alternatively, the MEC may determine to institute an investigation on its own initiative.

10.3 Investigation.

The MEC may reject a request for an investigation as unfounded and determine that action is unnecessary. Otherwise, the MEC shall notify the affected Practitioner of the initiation of an investigation and shall conduct such investigation as it deems necessary, which shall include, if reasonably feasible, 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, including external consultants, any required or requested Department review, and chart reviews, if applicable. The MEC may adopt as its own findings, either in whole or in part, review findings and conclusions conducted as a result of other Peer Review activity, including but not limited to external review undertaken in connection with a Focused Professional Practice Evaluation. Neither the investigation nor any other activities of the MEC in acting upon a request for an investigation shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these Bylaws shall apply during the investigation. In the event the affected Practitioner resigns his Medical Staff membership or Privileges during the course of an

investigation undertaken pursuant to this Section, such resignation shall be reported to the required agencies, including the NPDB, in accordance with state and federal laws.

10.4 Time for Taking Action; Notice; Right to Hearing.

Within thirty (30) days after initiating an investigation or within such reasonable additional time as the MEC deems necessary, the MEC shall take action on the matter. Within five (5) days after taking action, the MEC shall give written notice to the affected Practitioner and the Board stating which of the actions set forth in this Section the MEC has taken or recommended. If the action is of a type giving rise to fair hearing rights, the notice shall comply with applicable requirements.

10.5 Possible Actions.

Based on the findings from an investigation, the MEC may take the following actions: (1) close the investigation without action; (2) issue a letter of warning or reprimand or initiate an on-going Focused Professional Practice Evaluation; (3) recommend terms of probation or mandatory coadmitting or consultation requirement; (4) recommend reduction, suspension, or revocation of Clinical Privileges; (5) recommend that an already imposed summary suspension of membership or Clinical Privileges be terminated, modified, or sustained; (6) recommend that the Practitioner's membership be suspended or revoked; or (7) take or recommend other actions deemed by the MEC to be reasonable and appropriate under the circumstances. The MEC may summarily suspend a Practitioner's Privileges in whole or in part if the facts gathered during the investigation demonstrate that grounds for summary suspension are present.

10.6 Notice to CEO.

The Chief of Staff of the MEC shall promptly notify the CEO in writing of each request for investigation received by the MEC and the date of its receipt, and shall keep the CEO fully informed of all communications, meetings, and actions in connection with each request.

10.7 Finality of Action.

10.7.1 An MEC decision to close an investigation, issue a warning or reprimand, or take other corrective action that is not reportable to the NPDB shall be final and without recourse to hearing and appeal rights under these Bylaws. Failure of the MEC to act on a request for investigation shall be deemed to constitute dismissal of the request for investigation and the investigation shall be deemed closed.

10.7.2 An MEC decision to take any action that will give rise to hearing and appeal rights under these Bylaws shall be in the form of a recommendation to the Board. The Board shall act on the recommendation following exercise of the fair hearing and appellate rights by the Practitioner unless such rights are waived.

10.8 Use of Membership/Privileges.

The affected Practitioner shall retain the use of his Medical Staff membership and right to exercise Clinical Privileges pending final action on the MEC's recommendation(s) by the Governing Board unless such Membership and/or Privileges are otherwise suspended as provided in this Article.

10.9 Summary Suspension or Summary Restriction.

10.9.1 Grounds; Authority.

All or any portion of a Practitioner's Clinical Privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health or safety of any individual. The following persons shall be authorized to take summary action: the Chief Medical Officer, Chief of Staff, the Chair of a clinical Department, the MEC, or the CEO. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the MEC. Upon initiation of a summary suspension the Chief of Staff or, if unavailable, the Chair of a clinical Department, shall assign alternative coverage for the Practitioner's currently hospitalized patients.

When no person or committee referenced above is available or willing to take summary action, the Governing Board, or its designee, may take such action if a failure to do so would be likely to result in imminent danger to the health or safety of any individual. Prior to exercising this authority, the Governing Board, or its designee, shall make reasonable attempts to contact the Chief of Staff, as the designee of the Medical Staff, another Medical Staff officer or the Chair or designee of the affected Practitioner's clinical Department. Summary action by the Governing Board which has not been ratified by the MEC within three (3) working days shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

10.9.2 Effective Date; Notice.

A summary suspension or restriction shall become effective immediately upon imposition, and the person or body imposing same shall promptly give oral and written notice of the suspension or restriction to the suspended Practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or placed in the U.S. mail to the suspended Practitioner, or sent by national courier service, whichever occurs first. In addition to providing the reasons for and duration of the suspension, the notice shall inform the suspended Practitioner: (i) of his right to an informal interview with the MEC; (ii) whether the action is reportable pursuant to any state or federal statute; and (iii) that the MEC may take action to terminate, modify or continue the suspension within 29 days. A copy of the notice shall promptly be delivered to the CEO, the MEC, and the Governing Board.

10.9.3 Investigation.

The MEC, before taking further action, shall conduct the investigation it deems necessary, which shall include offering the Practitioner an opportunity to meet with the MEC to respond to the suspension or restriction and explain his or her position with regard to the conduct or circumstances at issue. Neither the investigation nor any other activities of the MEC in determining whether to terminate, modify or continue the summary suspension or restriction shall constitute a hearing; they shall be informal, and none of the fair hearing rights under the Bylaws shall apply. In the event the affected Practitioner resigns his or her Medical Staff membership or privileges during the course of an investigation, such resignation shall be reported to the required regulatory authorities in accordance with state and federal law.

10.9.4 Further Action; Time.

Within twenty-nine (29) days after the date of the summary action, the MEC shall terminate, modify, or continue for a definite or indefinite period the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these Bylaws. Regardless of whether the MEC continues, terminates or modifies the summary suspension, it shall also decide whether to recommend adverse action against the Practitioner's Medical Staff membership and Clinical Privileges. The MEC shall promptly give written notice of its determination to the suspended Practitioner, the CEO and the person or body who imposed the suspension or restriction (if other than the MEC).

10.9.5 Right to Hearing.

Following the recommendation of the MEC regarding further action, the fair hearing/appeal rights shall apply; provided, however, a Practitioner shall only be entitled to fair hearing and appeal rights in the event that the summary suspension or summary restriction is reportable to the NPDB (*i.e., the action lasts longer than 30 days*).

10.10 Automatic Suspension or Withdrawal of Membership and/or Clinical Privileges.

10.10.1 The following shall result in the automatic suspension, revocation, or withdrawal of Clinical Privileges or be deemed a voluntary resignation from the Medical Staff and shall not entitle the affected Practitioner to the fair hearing and appeal rights specified in the Bylaws, unless otherwise expressly provided.

(a) The CEO shall impose the automatic action contemplated under this section following reasonable inquiry and affording the affected Practitioner a reasonable opportunity to respond before action is taken.

(b) The affected Practitioner shall be informed of the automatic suspension in writing, delivered by personal delivery or U.S. Mail or national courier, which shall set forth the effective date and the reason for the suspension, termination, or withdrawal.

10.10.2 Failure to Complete Medical Records.

Suspension shall be imposed for failure to complete medical records within the time frames for completion specified in the Rules and Regulations. Clinical Privileges shall be reinstated upon confirmation that the medical record(s) at issue have been completed. Failure to complete the medical records at issue within four (4) weeks of suspension shall be deemed to constitute a voluntary resignation from the Medical Staff and the voluntary relinquishment of all Clinical Privileges. Accumulation of more than three (3) medical record suspensions in any consecutive twelve (12)-month period shall also be deemed to constitute a voluntary resignation from the Medical Staff and voluntary relinquishment of all Clinical Privileges.

10.10.3 Failure to Write Legible Orders

Admitting privileges and surgical or procedure privileges may be suspended for illegible orders. Illegible is deemed to occur when there are orders that three other individuals cannot read. Suspension will occur automatically after the Practitioner has been notified, in writing, on three separate occasions regarding legibility. Privileges shall be reinstated if the Practitioner will write orders only electronically on a going forward basis

or otherwise demonstrates to the reasonable satisfaction of the MEC that sufficient remedial measures have been taken.

10.10.4 Licensure.

Whenever a Practitioner's license to practice in this State is revoked, restricted, suspended, surrendered, or made subject to any probationary provisions by the medical licensing agency, the Practitioner's Staff membership and Clinical Privileges shall be automatically suspended. Automatic suspension pursuant to this Section shall not give rise to fair hearing and appeal rights. A Medical Staff Member shall promptly inform the CEO of any change in his licensure status, or entry into an Order with any licensing Board whether public, non-public, private or non-disciplinary. Reinstatement of Medical Staff membership and Clinical Privileges shall be subject to the recommendations of the Medical Executive Committee upon petition of the Practitioner and to the approval of the Governing Board.

10.10.5 Drugs/Medication.

Upon receipt by the Hospital of notice that a Practitioner's right to prescribe or obtain controlled substances or medications has been suspended, revoked, placed on probation, stayed or otherwise restricted by the applicable governmental agency, such actions and terms shall automatically apply to the Practitioner's ability to prescribe controlled substances in the Hospital. Whenever a Practitioner's DEA registration expires, the Practitioner's right to prescribe medications shall be automatically suspended until the DEA registration is renewed.

10.10.6 Loss of Malpractice Insurance.

If a Practitioner fails to maintain professional liability insurance in the amounts, including tail coverage, required by the Governing Board pursuant to resolution provided to the Medical Staff, or fails to provide evidence of such coverage upon request of the CEO or his designee, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the Practitioner provides evidence that he has secured the required professional liability coverage. Failure to provide such evidence within two (2) weeks after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical Staff.

10.10.7 Felony Indictment or Conviction.

The Medical Staff membership and Clinical Privileges of a Practitioner who has been indicted for a felony shall be automatically suspended effective immediately and shall remain in effect until the matter is resolved. If the matter is convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically withdrawn effective immediately upon such conviction or plea, regardless of whether an appeal is filed. The withdrawal is a permanent administrative action.

10.10.8 Suspension, Exclusion, Debarment or Sanction under any Federal or State Health Care Agency.

The Medical Staff membership and Clinical Privileges of a Practitioner who has been excluded or debarred under the Medicare or Medicaid program or by any governmental licensing agency, or convicted of any offense related to health care, or listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation shall be automatically withdrawn. The withdrawal shall become

effective immediately upon such debarment, exclusion, sanction, conviction or listing, regardless of whether an appeal is filed. Fair hearing and appeal rights shall not apply.

10.10.9 Loss of Board Certification.

If the Practitioner fails to obtain or maintain board certification as required by the applicable certification board and these bylaws, the Practitioner will be deemed to have voluntarily resigned from the Medical Staff. Notwithstanding the foregoing, a Practitioner may continue to be granted membership on the Medical Staff if the Governing Board, following recommendation by the MEC, determines in its sole discretion: i) that the Practitioner is otherwise qualified for Medical Staff membership; ii) that there is an urgent need for Physician services in the specialty to maintain the Hospital's complement of necessary services; and iii) that the Hospital has exercised reasonable diligence under the circumstances to secure the necessary coverage by a Physician holding board certification. .

10.10.10 Movement of Residence.

If the Practitioner moves his or her primary residence or office outside the geographic area identified in Article 6, the Medical Staff membership and Clinical Privileges of the Practitioner shall be automatically suspended during the time in which the Practitioner is located outside of the geographic area identified in Article 6.

10.10.11 Required Training.

If the Practitioner does not participate in required training, his or her membership on the Medical Staff and Clinical Privileges shall be automatically suspended until such training is completed.

10.10.12 Compliance with Emergency Department Coverage Requirements.

In the event a Practitioner fails to comply with the Emergency Department coverage requirements established by the Hospital, his or her Clinical Privileges may be subject to disciplinary action up to and including automatic suspension until the Hospital determines that the Clinical Privileges may be reinstated.

10.10.13 Peer Review and Quality Management Issues.

In the event a Practitioner fails to respond to questions about quality, professional competence, or professional conduct from a Department, peer review committee, or other body with jurisdiction over quality issues at the Hospital, the affected Practitioner's Clinical Privileges may be subject to disciplinary action up to and including automatic suspension until all quality responses have been received. Likewise, in the event a Practitioner refuses to submit to a mental, physical, or psychological assessment requested by the MEC, the Practitioner's Clinical Privileges may be subject to disciplinary action up to and including automatic suspension until the assessment has been completed and any requested documentation relating to the assessment has been delivered to the MEC.

10.10.14 Falsification of Application.

In the event it is determined that a Practitioner has falsified information on his or her application for appointment or reappointment, the Clinical Privileges of the Practitioner shall be automatically suspended.

10.10.15 Failure to Comply with Reporting Obligations.

In the event that a Practitioner fails to comply with reporting obligations outlined in the Bylaws, his or her Clinical Privileges shall be automatically suspended until the matter may be resolved by the MEC.

10.10.16 Loss of Membership or Clinical Privileges at a Healthcare Facility.

In the event a Practitioner's membership or clinical privileges at another Healthcare facility are denied, revoked, suspended, or terminated for reasons relating to professional competence or conduct, then the Practitioner's Clinical Privileges and Membership at the Hospital shall be automatically terminated or suspended if deemed necessary to protect the safety of patients, by the MEC and Governing Board. Likewise, if a Practitioner resigns or restricts his or her privileges at another Healthcare facility while under an investigation or in order to avoid an investigation related to professional competence or conduct at that facility, then the Practitioner's Clinical Privileges at the Hospital shall be automatically withdrawn. The duration and extent of the automatic suspension, withdrawal, or termination of the Practitioner's Membership and Clinical Privileges at the Hospital shall be the same as the action taken at the other facility.

10.11 Investigatory Suspension

The CEO or his or her designee, after consultation with the Chief of Staff, or one or more members of the MEC, or an elected officer of the Medical Staff, may suspend a Practitioner for up to 14 days to carry out an investigation to determine the need for corrective action. Such suspension shall be precautionary in nature and the suspension shall terminate automatically at the earlier of the timeframe established at the time of the imposition of such suspension or 14 days, whichever occurs first. Because the sole purpose of the investigatory suspension is to afford the MEC time to inquire into the need for professional review action, the investigatory suspension shall not be deemed disciplinary action related to the conduct or competence of the subject Practitioner. Fair hearing and appeal rights shall not apply. An investigatory suspension shall become effective immediately upon imposition, and the person imposing same shall promptly give written notice of the suspension or restriction to the suspended Practitioner, stating who imposed the suspension and the reasons for same. The notice shall be deemed to have been given to the suspended Practitioner on the earliest of the date on which it was personally delivered, the date the notice was placed in the U.S. Mail, or the date sent by national courier service. A copy of the notice shall promptly be delivered to the CEO, the suspended Practitioner, the MEC and the Governing Board.

10.12 Behavioral Suspension

The Chief of Staff, on behalf of the MEC and following consultation with the CEO, may summarily suspend a Practitioner for up to 14 days when information is brought to his or her attention that demonstrates that such Practitioner may have engaged in behaviors that are contrary to the Code of Conduct. A behavioral suspension under this section shall be for the purpose of investigating the need for disciplinary action under these Bylaws and shall only be imposed consistent with the Rules and Regulations governing Disruptive Behavior or applicable policy. Because the sole purpose of the behavioral suspension is to afford the MEC time to inquire into a potentially grave situation, the behavioral suspension shall be deemed not to relate to the professional conduct or competence of the affected Practitioner. If disciplinary action is pursued, the procedures shall be in accordance with the rules governing the review of Medical Staff Member conduct as set forth in Sections 10.2 through 10.8 above and Article 11.

10.13 Alternate Patient Coverage.

Immediately upon the imposition of a suspension, termination, restriction or revocation, the Chief of Staff or responsible Department Chair shall arrange for alternate medical coverage for the patients of the subject Practitioner by a member of the Medical Staff if the Practitioner's Privileges to provide the necessary professional services for the patient were adversely affected. The wishes of the patients shall be considered in the selection of such alternate coverage.

10.14 Application to Medical Staff After Suspension or Revocation.

A Practitioner whose Medical Staff membership or Clinical Privileges are automatically suspended or revoked may apply for reinstatement, but such application shall be offered and processed as an initial applicant.

ARTICLE 11.

FAIR HEARING AND APPEAL PROCEDURES

11.1 General Provisions; Definitions; Settlement.

11.1.1 Duty to Exhaust Remedies.

Fair hearing and appeal procedures shall be exhausted before attempting to obtain judicial relief related to any issue or decision which may be subject to fair hearing and appeal. The absence of an interlocutory appeal process for reviewing any alleged violation of the Bylaws or the affected Practitioner's fair hearing rights does not warrant judicial intervention.

11.1.2 Definitions.

For the purposes of this Article, the following definitions shall apply.

(a) Adverse Action: An action or recommendation by the MEC that is grounds for fair hearing.

(b) Affected Practitioner: The Medical Staff member or applicant for membership with respect to whom any of the actions specified in Section 11.3 has been taken or recommended, and whose membership or privileges may be affected thereby.

(c) Notice: A written communication delivered personally to the Affected Practitioner or sent by United States Postal Service, first class postage prepaid, certified or registered mail, return receipt requested, or national courier delivery service with receipt such as FedEx, UPS or DHL, addressed to the addressee at his address as it appears in the records of the Hospital. Copies shall be as effective as the original for the purpose of giving notice.

(d) Date of Receipt. A Notice shall be deemed received on the date it was actually received or five (5) working days after it was mailed first class postage prepaid or sent by national delivery service, whichever occurs first.

11.1.3 Resolutions.

At any time following receipt of notice of a recommendation or action which would entitle a Practitioner to request a hearing under this Article, the Practitioner and the MEC may discuss voluntary resolution of the matter. Upon such request and subject to the Practitioner's waiver of time requirements in order to allow such discussions to proceed, the MEC may authorize one or more of its members to conduct confidential discussions with the Practitioner; provided, that the MEC shall not be obligated to conduct such discussions if it concludes that the request is interposed primarily for delay or that a resolution is not feasible. If the Practitioner and the MEC reach a written agreement which could resolve the matter, the Chief of Staff shall promptly notify the CEO and the Governing Board. Any such resolution shall be final only upon approval by the Governing Board and documentation of the terms of the resolution.

11.2 Mediation.

11.2.1 Circumstances Providing a Right to Request Mediation.

A Practitioner is entitled to request mediation in the following circumstances:

(a) The Practitioner is subject to an Adverse Action under the Bylaws, and the Practitioner believes that mediation is desirable; or

(b) The Practitioner can provide credible evidence that the Medical Executive Committee failed to take action on the Practitioner's completed application within ninety (90) days of its receipt of such application.

11.2.2 Mediation Request.

The Practitioner's written request for mediation must be delivered to the CEO and Chief of Staff and state the reason the Practitioner believes mediation is desirable or provide credible evidence of the Medical Executive Committee's failure to take action on a complete application within the required time period. If a hearing pursuant to this Article has already been scheduled, the request must be received at least twenty (20) days prior to the first scheduled hearing date. Unless otherwise agreed to by the parties, mediation conducted pursuant to an appropriate request must be completed prior to the date of the hearing. Under no circumstances may a request for mediation or the mediation process delay a hearing that has been scheduled in accordance with this Article, unless mutually agreed to by the parties. Neither a request for mediation nor the actual mediation process may delay the filing of any report required by law.

11.2.3 Mediator Selection.

The mediator shall be selected by the CEO in consultation with the Chief of Staff. The mediator must have the qualifications required by state law and experience in medical staff issues and disputes. The fees of the mediator shall be paid jointly by the requesting Practitioner and the Hospital.

11.2.4 Agreement to Participate in Mediation.

The CEO and the Practitioner must sign an agreement to participate in mediation as required by the mediator or as agreed to by the CEO and the requesting Practitioner. The agreement to mediate may not require that the Medical Executive Committee, Board, or Hospital violate any Bylaws, legal, or accreditation requirement, or take any action not permitted by law; provided, however, the mediation agreement shall include provisions regarding confidentiality, protection from discovery, and other issues relevant to the mediation. The Chief of Staff shall designate an individual to participate in the mediation ("Designee") as the representative of the the Medical Executive Committee. The CEO or the CEO's designee shall serve as the representative of the Board.

11.2.5 Proposed Solution.

At the conclusion of the mediation, the mediator may offer a proposed solution. The proposed solution is not binding and may be accepted or rejected by either the Designee, the CEO or designee or the Practitioner. The proposed solution may not require that the Medical Executive Committee, Board, or Hospital violate any Bylaws,

legal, or accreditation requirement, or take any action not permitted by law. If the proposed solution is acceptable to the Practitioner and the Designee, the Designee shall agree to present the proposed solution for consideration at the next meeting of the MEC. The terms and conditions of the proposed solution shall be set forth in writing as a recommendation to be forwarded to the MEC for initial approval and any follow-up recommendations from the MEC, and then forwarded to the Board for final approval. If the proposed solution is rejected by either the Practitioner or the Designee, the Practitioner may request a hearing, or move forward with any hearing already scheduled.

11.2.6 Binding Resolution by Mediation.

While the mediation recommendation shall be signed at the conclusion of the mediation by the Designee and the Practitioner, it shall not be binding on the Hospital until approved in writing by the CEO and the Chair of the Board.

11.2.7 Mediation Standards.

The mediation shall be conducted in accordance with the standards of the American Health Lawyers Alternative Dispute Resolution Service or as otherwise agreed by the parties. The use of a mediator shall not result in a loss of the peer review privilege. The Practitioner and the Designee may be accompanied in the mediation by counsel of their choice.

11.2.8 Request by the Hospital.

The CEO also has the right, as an alternative to a hearing, to ask the Practitioner who is the subject to an adverse recommendation if he or she would agree to attempt to solve the issues that are the subject of the adverse recommendation by mediation prior to the use of the fair hearing process. If no agreement is reached through mediation, the Affected Practitioner's right to a hearing and appellate review shall not be waived. If mediation is utilized, the time deadlines established by this provision shall not be binding until or unless the hearing process begins.

11.3 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 in the event the action adversely affects the Practitioner's Staff membership and/or Clinical Privileges for more than 30 days and is based on the practitioner's professional competence or conduct that could adversely affect patient care.

11.3.1 denial of initial appointment to the Medical Staff.

11.3.2 denial of Staff reappointment.

11.3.3 termination of appointment based on failure to advance from a provisional to regular staff category for reasons related to professional competence or conduct.

11.3.4 suspension of Staff membership or Clinical Privileges.

11.3.5 revocation of Staff membership or Clinical Privileges.

11.3.6 denial or limitation of Clinical Privileges, including denial of temporary privileges for reasons relating to competence or conduct.

11.3.7 reduction in Clinical Privileges.

11.3.8 summary suspension of Clinical Privileges for more than thirty (30) consecutive days.

11.3.9 mandatory consultation, proctoring or co-admitting requirements when the consultant, proctor or co-admitter must approve the procedure or must observe the procedure performed by the affected Practitioner for a period of more than thirty (30) days.

11.4 Notice of Adverse Action or Recommended Action; Request for Hearing.

Whenever any of the actions constituting grounds for a hearing has been taken or recommended, the Chief of Staff shall give the Affected Practitioner Notice of same.

11.4.1 The Notice shall:

(a) describe what action has been taken or recommended.

(b) state the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested).

(c) advise the Practitioner that he has the right to request a hearing and, that such request must be in writing and received by the CEO within thirty (30) days after the Date of Receipt of the Notice or such right will be waived.

(d) summarize the Affected Practitioner's rights in the hearing and enclose a current copy of the Medical Staff Bylaws.

(e) state whether the action, if finally adopted, will be reported to the appropriate licensing entity and to the NPDB.

11.4.2 The Affected Practitioner shall have thirty (30) days following the Date of Receipt of the Notice within which to request a hearing. A request for hearing must be in writing and delivered to the CEO. Failure of the Affected Practitioner to request a hearing as required shall be deemed to constitute a waiver of all hearing and appeal rights under these Bylaws. The matter shall thereupon be forwarded to the Governing Board for final disposition. The CEO shall give notice to all parties of any such waiver and acceptance.

11.5 Time and Place of Hearing.

11.5.1 Upon receipt of a proper request for hearing, the Chief of Staff shall promptly schedule a date for a hearing, and give Notice to the parties of the time, place, and date thereof, and shall deliver a copy of these Bylaws to the Affected Practitioner. Such Notice shall include a list of expected witnesses for the MEC. The MEC may amend the list in accordance with the procedures set forth in Section 11.11.1.

11.5.2 The hearing shall be scheduled for a date at least thirty (30) days after the date of the Notice regarding the time and place of the hearing and not more than sixty (60) days from the Date of Receipt of the request for a hearing by the

CEO, except that when the request is received from a Member who is under suspension. In the event the Affected Practitioner is subject to a suspension, then the hearing shall be scheduled at least thirty (30) days after the date of the Notice regarding the time and place of the hearing and not later than forty (40) days from the date of receipt by the CEO of the request for hearing. The hearing may be scheduled for later dates upon the mutual agreement of the parties. The parties and the MRC shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

11.6 Statement of Charges.

As a part of, or together with, the Notice of Hearing, the MEC shall state the acts or omissions with which the Affected Practitioner is charged, including, if applicable, a list of chart numbers under question, if any, and the reasons for the action or recommendation. Amendments to the Statement of Charges may be made from time to time, but not later than the close of the case by the Medical Staff representative at the hearing. 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 to the Affected Practitioner, the hearing officer, and each party. If the Affected Practitioner 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.

11.7 MRC Appointment, Removal, and Qualifications.

Promptly after a hearing has been properly requested, the Chief of Staff shall appoint an MRC. The MRC shall consist of at least three (3) but not more than five (5) members of the Medical Staff. The Chief of Staff shall designate one member of the MRC as its chair. If reasonably feasible, at least one member of the MRC shall have practice experience, education or training the same or sufficiently similar to the practice area of the Practitioner under review. The members of the MRC shall be impartial and shall not have acted as accusers, investigators, fact-finders or initial decision makers in connection with the same matter nor shall they be in economic competition with the Affected Practitioner. The Chief of Staff shall be authorized to appoint individuals to serve on the MRC who are not members of the Medical Staff if there is not a sufficient number of Medical Staff Members available or if there is not a member with similar education, training, experience. The Chief of Staff shall provide the Affected Practitioner with notice of the members of the MRC, and the Affected Practitioner shall have the right to challenge the appointment of any member of the MRC as provided in 11.11.1(c). The Chief of Staff may also appoint up to two (2) alternates, who will be able to serve on the MRC in the event that an original appointee is unavailable for the duration of the hearing.

11.8 Hearing Officer; Chairman of MRC.

The CEO shall appoint a hearing officer to preside over the hearing. The hearing officer shall be an attorney and should be familiar with the law applicable to medical staff matters. The hearing officer 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 hearing officer shall not act as a prosecuting officer or advocate. The hearing officer shall act as advisor to the MRC as to procedural matters, including the drafting of its decision and report, but he or she shall not be entitled to vote. The CEO shall provide the Affected Practitioner with notice of the hearing officer who has been initially appointed, and the Affected Practitioner shall have the right to challenge the hearing officer by providing the CEO written notice of his or her objections. Any objections must be submitted to the CEO at least ten

(10) days prior to the date of the hearing. The CEO shall make the final determination on the appointment of the hearing officer.

11.9 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 shall be granted upon agreement of the parties or by the hearing officer on a showing of good cause. The MRC shall promptly give notice to the parties of each such postponement.

11.10 Medical Staff Representative.

After a hearing has been properly requested, the Chief of Staff shall promptly appoint a Medical Staff member ("Medical Staff representative") to present the case on behalf of, and otherwise represent the MEC. The Chief of Staff may, in its sole discretion, remove or replace the Medical Staff representative at any time.

11.11 Hearing Procedures

11.11.1 Pre-Hearing Exchange of Information and other Procedures.

(a) Discovery proceedings are not authorized.

(b) The Affected Practitioner shall have the right to inspect and copy at the Practitioner's expense documentary information relevant to the charges which the MEC has in its possession or under its control, as soon as practicable after the receipt of the Practitioner's request for a hearing. The MEC shall have the right to inspect and copy at its expense documentary information relevant to the charges which the Practitioner has in his possession or control as soon as practicable after receipt of the MEC's request. The failure of either party to provide access to this information at least ten (10) days before the hearing shall constitute good cause for a continuance or for the hearing officer to bar or otherwise limit the introduction of any documents not provided to the other party. The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable Practitioners, other than the Affected Practitioner. The hearing officer shall consider and rule upon any dispute or controversy concerning a request for access to information. The hearing officer may impose safeguards to protect the Peer Review process and justice. When ruling upon requests for access to information and determining the relevancy thereof, the hearing officer shall, among other factors, consider the following:

(i) whether the information sought may be introduced to support or defend the charges.

(ii) the exculpatory or inculpatory nature of information sought, if any *(i.e.,* whether there is a reasonable probability that the results of the hearing would be influenced significantly by the information if received into evidence).

(iii) the burden imposed on the party in possession of the information sought, if access is granted.

(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(c) At least ten (10) days prior to the date of the hearing, the Affected Practitioner may submit a written objection challenging the appointment of any member of the MRC. Such objections shall be supported with a statement of reasons and sent to the hearing officer. The hearing officer shall have the authority to make the final determination on the appointment of MRC members.

(d) At the request of either party, the parties must exchange at least eight (8) days before the hearing: (a) lists of witnesses expected to testify at the hearing; and (b) copies of all documents expected to be introduced at the hearing. Failure of a party to produce these materials, or to update them, at least eight (8) days before the commencement of the hearing, shall constitute good cause for the hearing officer to grant a continuance, or to bar or otherwise limit the introduction of any documents not provided to the other party or testimony from witnesses not identified pursuant to this provision.

(e) It shall be the duty of the Affected Practitioner and the MEC to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised on the record at the hearing and when so raised shall be preserved for consideration at any appeal.

11.11.2 Failure to Appear.

Failure of the Affected Practitioner to appear at the hearing and to proceed with the presentation of his or her case shall be deemed to constitute the Affected Practitioner's voluntary acceptance of the recommendation or action and waiver of all hearing and appeal rights under these Bylaws, unless the MRC finds good cause for such failure, based upon written request by the Affected Practitioner or his representative.

11.11.3 Representation.

The Affected Practitioner and the MEC shall be entitled to be accompanied by and represented at the hearing by counsel or by a person of their choice. If the Affected Practitioner chooses not to be represented by counsel during the hearing, the MEC shall not be represented by legal counsel during the hearing. Nothing in this Section prohibits either party from consulting legal counsel in conjunction with the hearing, including before and during recesses from the hearing.

11.11.4 Record of the Hearing.

The MRC proceedings shall be taken and transcribed by a court reporter, and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests. There shall be no other record of hearing testimony.

11.11.5 Oath of Witness.

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

11.11.6 Rules of Evidence.

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. Hearsay evidence may be introduced, subject to ruling by the hearing officer.

11.12 Hearing Rights.

At the hearing, parties or their representatives shall have the right to:

11.12.1 be represented by an attorney or other person of their choice.

11.12.2 call and examine witnesses on relevant evidence and to cross examine witnesses.

11.12.3 introduce relevant documentary evidence.

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

11.12.5 submit a written post-hearing statement following the presentation of evidence in the length and within the timeframe ordered by the hearing officer.

11.12.6 upon completion of the hearing, receive the written recommendation of the MRC, including a statement of the factual basis for the decision.

11.12.7 upon completion of the hearing, receive a written decision of the Hospital or the Governing Board, including a statement of the basis for the decision.

11.13 Conduct of the Hearing.

Generally, the hearing shall be conducted as follows:

11.13.1 Each party shall have an opportunity to make a ten (10) minute opening statement summarizing the background of the matter and the salient general conclusions the respective party expects to prove.

11.13.2 The Medical Staff representative or counsel for the Medical Staff shall then present the facts upon which the Medical Staff is relying, by calling the witnesses and presenting the documentary evidence to support the case. Any person, including an opposing party who is present, may be called in support of the case.

11.13.3 At the close of the Medical Staff representative's case, the Affected Practitioner or his representative shall make a case presentation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case.

11.13.4 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 hearing officer as to order, time, relevance, and repetition.

11.13.5 Any relevant material contained in Medical Staff files regarding the Affected Practitioner is admissible, including but not limited to applications, references, and accompanying documents.

11.13.6 Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the hearing officer, to give closing statements and to submit a written post-hearing statement (which may include a written reply to the post-hearing statement submitted by the other party), the due date for which shall be established by the hearing officer.

11.13.7 Upon the submission of the post-hearing written statement, the hearing officer shall declare the hearing finally adjourned. The MRC shall thereafter, at the convenience of its members, deliberate in order to reach its decision.

11.13.8 Reasonableness shall 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 hearing officer after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only.

11.13.9 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 hearing officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the hearing officer, leave the hearing. Unless directed otherwise for good cause by the hearing officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the Affected Practitioner or a witness, he shall have the right to submit to the MRC, not later than ten (10) days after such exclusion (unless extended by the hearing officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.

11.13.10 In addition to the parties and their counsel and subject to reasonable restriction by the hearing officer, the following shall be permitted to attend the entire hearing in addition to the MRC, the hearing officer, court reporter, and parties: the CEO or designee, the Medical Staff Services coordinator or assistant, one (1) key consultant for each party, and one (1) or more representatives of the entity that owns the Hospital.

11.14 Burden of Proof.

A Practitioner who is challenging an adverse action or recommendation shall have the burden of proving, by a preponderance of the evidence, that the recommendation or action at issue is not supported by the evidence, and is arbitrary, capricious or in violation of these Bylaws or other Governance Documents.

11.15 Decision and Report of MRC; Notice.

Within thirty (30) days after adjournment of the hearing, the MRC shall deliberate and render and deliver to the CEO a written report and decision. The MRC may recommend that the Governing Board affirm, terminate or modify the action or recommendation that prompted the hearing. If the recommendation is to modify, the MRC shall identify the modifications recommended. The decision and report shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn. The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. It shall include sufficient detail to enable the parties and the Governing Board to determine the basis for the MRC's decision on each issue contained in the statement of charges. It shall also contain a description of the rights in the appeal process under these Bylaws. The CEO within five days after receiving the decision and report, shall send a copy to the parties.

11.16 Governing Board Action After MRC Decision.

The Governing Board 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 the appeal. If an appeal is timely requested, the Governing Board shall take no action except in compliance with the procedures and provisions of this Article. If the appeal process is not timely requested, the Governing Board shall make its final decision.

11.17 Appeal to Governing Board.

11.17.1 Time for Requesting Appeal.

Within fifteen (15) days after receipt of the decision of the MRC, either the Affected Practitioner or the MEC may request an appeal. The request shall be in writing and must be received by the CEO within the applicable time period set forth above. The CEO shall immediately deliver copies of the request to the Governing Board and to the Chief of Staff and other parties. The request shall set forth the ground(s) for appeal. If an appeal is not requested as set forth in this paragraph, the party shall be deemed to have waived all rights to appeal.

11.17.2 Nature and Effect of Appeal Process.

The appeal process shall be conducted by the Governing Board or a committee thereof and all references to the "Governing Board" shall include such committees. The appeal process shall consist of a review of the prior proceedings and decision, at least one meeting of the appeal committee and the parties, deliberations, review of any further recommendations, and a final decision. The Governing Board shall give great weight to the MRC decision, and shall not act arbitrarily or capriciously. The appeal body may however, exercise its independent judgment in determining whether a Practitioner was afforded a fair hearing, and whether the decision is reasonable and warranted by the facts determined, and in furtherance of quality care. In its final decision the Governing Board may affirm, modify or reverse the decision of the MRC. The Governing Board

decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached. No person or entity that participated in bringing the charges or in officially reviewing the matter shall participate in the appeal process, even if such removal leaves the Governing Board with less than a quorum.

11.17.3 Grounds for Appeal.

The grounds for appeal are limited to:

(a) substantial and prejudicial failure of the MRC to comply with these Bylaws or other Governance Document or to afford a fair hearing;

(b) the action or recommendation that prompted the hearing, or any substantial part was unreasonable, arbitrary or capricious; or

(c) the MRC's decision or any substantial part 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.

11.17.4 Notice of Time, Date, Place of Appellate Review Meeting.

The Governing Board shall, within thirty (30) days after receipt by the CEO of a timely request for appeal, schedule a date for an appellate review meeting. The Governing Board shall, not less than ten (10) days prior to the date of the appellate review meeting, give the parties' written notice of the time, place, and date. The date thereof shall be not less than ten (10) days, nor more than forty (40) days from the Date of Receipt by the CEO of the request for appeal, except that when a request for appellate review is from a member who is then under suspension, the meeting shall be held as soon as reasonably practicable from the date of receipt of the request. The date for the meeting may be extended by the chairman of the Governing Board for good cause.

11.17.5 Appellate Review Proceedings.

The appellate review shall be conducted as follows:

(a) The Governing Board shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written statements submitted by the parties. The Hospital shall provide the Board, at the Hospital's expense, a transcript of the hearing. The Affected Practitioner shall pay for a copy of the transcript if desired. The Governing Board may, 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 Board's own motion, or upon the request of a party if, not less than seven (7) days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the Governing Board 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 Board shall give notice of its decision in such matters to all parties as soon as reasonably possible.

(b) The Governing Board shall appoint a hearing officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the Governing Board as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision.

(c) Each party shall have the right to submit a written brief in support of the party's position on appeal, provided that copies of such brief shall be given to all other parties at such time as may be directed by the Governing Board.

(d) Each party and/or party representative who may be an attorney, shall have the right to appear personally and make oral argument at the appellate review meeting. The Chair of the Governing Board or the hearing officer of the appellate review may set time limits for oral arguments. If a personal appearance is made, the parties and representatives present shall answer any questions posed by any member of the Governing Board.

(e) The Governing Board may, from time to time, adjourn and continue the appellate review 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 appeal in the matter. The Governing Board shall give notice to the parties of any such date and time, unless the parties were present when such date and time were announced by the Governing Board.

(f) At the conclusion of the appellate review, the Governing Board shall, at a time convenient to itself but generally within 30 days after receipt of all submissions of the parties, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, modify, or reverse the decision of the MRC.

(g) The Governing Board 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.

(h) No person shall disrupt any appellate review proceeding. Any person in attendance (whether a party or any other person) who disrupts such a meeting after being warned by the chairman of the Governing Board (or hearing officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such chairman (or the hearing officer), leave the meeting. Unless directed otherwise for good cause by the chairman (or the hearing officer), the meeting shall proceed in the absence of such excluded person.

11.17.6 Final Decision; Effective Date.

The appeal process shall conclude with the Governing Board's final decision in the matter which shall be made in accordance with the following rules:

(a) Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting, the Governing Board shall render its final decision, unless it refers the matter back to the MRC for further review and recommendation. The Governing Board shall give

great weight to the decision of the MRC and shall not act arbitrarily or capriciously. The Governing Board, however, may exercise its independent judgment in determining whether the hearing procedures in these Bylaws were followed.

(b) If the Governing Board refers the matter to the MRC for further review and recommendation, such referral may include instructions regarding further hearings on specific issues. The Governing Board shall give notice of such referral to the parties. The MRC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Governing Board within forty-five (45) days after the receipt of the referral from the Governing Board. Within forty-five (45) days after receipt of such recommendation, the Governing Board shall render its final decision.

(c) The Governing Board's final decision shall be in writing and shall include a statement of the Governing Board's basis for its decision. The decision shall be effective immediately and shall not be subject to further hearing or appeal. A copy of the decision shall be promptly transmitted to the Affected Practitioner, the CEO, the Chief of Staff and each party, in person or by mail.

11.18 Right to Only One MRC Hearing and Appellate Review.

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that is the subject of an MRC hearing or appeal.

11.19 Resignation or Withdrawal of Application.

Notwithstanding any other provision of these Bylaws, whenever the Affected Practitioner 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 the hearing; (d) amends an application or request with regard to the items that are the subject matter of the hearing; or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appeal proceedings with respect to the Practitioner, 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 Board, after receiving a written request from, or giving notice to, the Affected Practitioner, and determining that good cause exists for such reopening. Reporting of any such resignation, withdrawal or consent to the action or recommendation shall be in conformance with State and Federal regulations.

11.20 Confidentiality.

The fair hearing and appeal proceedings and the contents thereof shall be confidential. No one participating in the fair hearing/appeal process shall disclose or release any information from or about the activities proceedings to any person or the public. Information about patients shall be kept confidential in accordance with state and federal regulations and applicable Hospital policy.

11.21 Reporting

The Hospital shall report final actions and summary suspensions as required by the rules governing the NPDB and State law.

11.22 Dissemination of Adverse Privileging Decisions.

The Hospital shall disseminate the final decision to deny, revoke or revise Medical Staff membership and Clinical Privileges to the Chairman of the Department and appropriate internal personnel such as the director of the operating room, the director of nursing, and the director of ambulatory surgical services.

11.23 Exceptions to Hearing and Appeal Rights.

In addition to other exceptions set forth in these Bylaws, the hearing and appeal rights under these Bylaws shall not be available under the following circumstances:

11.23.1 Closed Departments/Exclusive Contracts.

The hearing and appeal rights under these Bylaws shall not be available to a Practitioner whose application for Medical Staff membership and Privileges is denied on the basis that the Privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.

11.23.2 Medico-Administrative Practitioner.

The applicability of hearing and appeal rights under these Bylaws to those persons serving the Hospital in a medico-administrative capacity shall only apply to the extent provided for in such Practitioner's contract with the Hospital. In the event of any conflict between the provisions of the contract and these Bylaws, the contract shall control.

11.23.3 Automatic Suspension or Termination of Privileges.

Unless otherwise expressly provided, the hearing and appeal rights under these Bylaws are not available to a Practitioner whose Medical Staff membership or Clinical Privileges are automatically suspended or terminated.

11.23.4 Allied Health Professionals.

Except as required by State law, Allied Health Professionals are not entitled to fair hearing and appeal procedures. Allied Health Professionals shall be afforded an opportunity to address the MEC in accordance with the grievance procedures set forth in these Bylaws and other applicable Governance Documents.

11.23.5 Removal from Emergency Room Call Panel.

Emergency Room call panel participation is not a benefit, right or privilege of Staff membership or Clinical Privileges, but rather it is an obligation. Fair hearing and appeal rights shall not be available for any action or recommendation affecting a Practitioner's duty to serve on emergency room call panel rosters.

11.23.6 Hospital Policy Decision.

The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (*e.g.,* to close a Department, Section or Service, or physical plant changes) that adversely affects the Staff membership or Clinical Privileges of any Member or applicant.

11.23.7 Failure to Meet Minimum Credentialing Requirements.

Hearing and appeal rights under these Bylaws shall not be available if Medical Staff membership or Privileges are denied, restricted, terminated or deemed resigned, or a Medical Staff category is changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules and Regulations.

11.23.8 Refusal to Process an Incomplete Application.

The Hospital has no duty to process an incomplete application. Hearing and appeal rights under these Bylaws shall not be available if an applicant or Medical Staff member has failed to complete his or her application.

11.23.9 Appointment or Reappointment for Less Than Two Years.

The period for appointment or reappointment to the Medical Staff may not exceed two years. A member of the staff who is appointed for less than two years has no hearing or appeal rights under these Bylaws.

11.23.10 Refusal of the Governing Board to Waive Requirements Set Forth in the Bylaws.

On occasion, the Governing Board may waive a requirement affecting a Staff member. The Governing Board's decision not to waive a requirement affecting an applicant to the Staff or Staff member shall not give the Practitioner a right to a hearing and/or appeal.

11.23.11 Imposition of Physical, Mental, or Psychological Health Assessment.

The MEC and the Governing Board have the authority to mandate that any applicant to or member of the Staff undergo a physical, mental, or psychological examination at the applicant's or Staff member's expense. The hearing and appeal rights under these Bylaws shall not apply to an applicant to the Staff or to a Staff member who is subject to an automatic suspension for failure to comply with such a request.

11.23.12 Investigatory Suspension That Does Not Exceed 14 Days.

A practitioner who is suspended for a period of up to 14 days for purposes of conducting an investigation has no right to the hearing and appeal rights under these Bylaws.

11.23.13 Termination of Appointment or Reappointment in Accordance with Practitioner's Contract with the Hospital.

When a Practitioner provides professional services as an independent contract, directly or indirectly pursuant to a contract with the Hospital, and his or her appointment or reappointment is terminated in accordance with the terms of the contract, the Practitioner shall have no hearing or appeal rights under the Bylaws.

11.23.14 Summary Suspension of 30 Days or Less.

The NPDB does not require a report if a Practitioner is suspended or if his or her Clinical Privileges are terminated for 30 days or less. Therefore, no Practitioner will be entitled to the hearing and appeal rights under these Bylaws in the event of such a suspension or termination.

11.23.15 Any Action Not Reportable to the NPDB.

A Practitioner shall not be entitled to any hearing and appeal rights of these Bylaws if the action taken against him or her is not reportable to the NPDB.

ARTICLE 12

ALLIED HEALTH PROFESSIONALS

12.1 General.

An Allied Health Professional shall:

12.1.1 Not be eligible for Medical Staff membership.

12.1.2 Be eligible to perform specified procedures as approved by the Board upon recommendation from the MEC and the relevant Department. A list of Allied Health Professional categories eligible to perform specified services at the Hospital shall be set forth in the Rules and Regulations of the Medical Staff.

12.1.3 Be credentialed and granted permission to perform specified services or procedures in accordance with this Article and any related Governance Documents. All AHPs, including Hospital employees, who seek to provide care that involves making a medical diagnosis and medical treatment decisions must submit an application and be evaluated by the Medical Staff and the Board in accordance with this Article.

12.2 Qualifications.

In order to receive permission to perform specified services or procedures, an AHP shall be required to demonstrate on a continuous basis that he or she:

12.2.1 Holds a current license, certificate or other credential as may be required by State law to perform the specified procedure.

12.2.2 Has the education, training, background, ability, current competence, professional judgment and physical and mental health status suitable to perform the procedures and services requested consistent with generally recognized standards of care.

12.2.3 Has two references from professionals other than his current employer in the relevant areas affirming his or her clinical competence.

12.2.4 Has and maintains professional liability insurance, including tail insurance in amounts required by the Board.

12.3 Applications for Appointment and Reappointment.

12.3.1 The pre-application process

Only those individuals will be eligible for an application who can demonstrate that they:

(a) Have a current and unrestricted license to practice their profession in the State;

(b) Demonstrate no record of revocation, suspension or probation of any health professional license or certification in any jurisdiction within the past 10 years, except for administrative reasons unrelated to crimes or professional competence or conduct;

(c) Have no history of conviction or deferred adjudication for a felony crime against a person and no history within the immediate past 10 years of (1) conviction or deferred adjudication for any felony; or (2) conviction or deferred adjudication for any misdemeanor offense related to health care, third party reimbursement, violence, or the use, prescription, distributions or furnishing of DEA Schedule I – V substances;

(d) Demonstrate no evidence of the denial, revocation, termination or involuntary relinquishment of the individual's clinical privileges or practice prerogatives in the same or similar area of practice at the Hospital or any other hospital or healthcare facility for reasons related to professional competence or conduct;

(e) Demonstrate no record of having been excluded, debarred or otherwise been the subject of adverse legal action taken by a state or federal agency in relation to participation in a federal or state health care program. For purposes of this subsection, the term "adverse legal action" means a Medicare or Medicaid imposed revocation of billing privileges, revocation or suspension by an accreditation organization; or exclusion or debarment from participation in a Federal or State health care program;

(f) Have all state and federal controlled substance certificates, including DEA permits, required for exercise of the Privileges sought.

(g) Demonstrate proof of professional liability coverage with a qualified carrier of the type and in the amount required by the Board that covers all privileges or practice prerogatives that would be requested; and

(h) Authorize the MEC or other committee engaged in Peer Review activity to receive reports of good standing and professional performance from prior employers and facilities at which he or she provided professional services and to conduct criminal background checks.

12.3.2 An individual determined to be ineligible for receipt of an application to be considered for specified services or procedures shall be notified of the criteria not satisfied. The individual shall be deemed to have accepted such determination, unless the individual, within thirty (30) days of the date of the notification, submits to the MEC documentation that demonstrates that the individual meets the criteria to receive an application. The decision of the Medical Executive Committee shall be final.

12.3.3 An application for appointment and reappointment as an AHP:

(a) Shall be processed in the same manner as applications submitted for Medical Staff membership and Clinical Privileges.

(b) Shall be subject to approval by the Board.

12.4 Prerogatives of AHPs.

An AHP shall be permitted to:

12.4.1 Perform services and procedures as specified by the Board.

12.4.2 Serve on Hospital and departmental committees.

12.4.3 Attend Department meetings as permitted.

12.4.4 Access grievance procedures as provided in 12.6.1 below.

12.5 Obligations of AHPs.

An AHP granted permission to perform specified privileges shall:

12.5.1 Provide care, treatment and services consistent with generally accepted standards of care and within the scope of his or her license and the permission granted by the Board.

12.5.2 Maintain continuing education as required by license or certification.

12.5.3 Participate in Peer Review activities as requested.

12.5.4 Notify the Chief of Staff in writing of any adverse credentialing action by any licensing board, hospital or health care facility, or termination of supervision or sponsorship agreement, where applicable under state law or if required by Hospital.

12.5.5 Comply with Bylaws, Rules and Regulations and Hospital policies.

12.6 Termination, Suspension, Revocation or Restriction of Permission to Perform Specified Procedures or Services.

12.6.1 Permission to perform specified procedures may be withdrawn or restricted in whole or in part by the Chairman of the Department to which the AHP has been assigned promptly upon determination that such action is in the best interest of patient care or the Hospital. Such circumstances shall include, but are limited to, loss oahpr restriction of license by the authorizing state agency, termination of supervision or sponsorship agreement, loss of or inadequate liability insurance coverage, failure to comply with Medical Staff Bylaws, Rules and Regulations or Hospital or Medical Staff policies, or professional conduct that is not consistent with generally accepted standards of care. The Department Chair shall make best efforts to contact the AHP before withdrawing such permission but shall not be required to do so. The Department Chair will provide the AHP written notice identifying the reasons for the withdrawal or modification of the AHP's privileges. Such notice shall be delivered personally or sent by U.S. mail or by national courier service.

An AHP may challenge a decision to deny, withdraw or restrict his or her ability to perform specified procedures by submitting a written request for reconsideration to the Executive Committee setting forth the basis for the request.

The Executive Committee shall review the written documentation as soon as reasonably practicable and may invite the Allied Health Professional to appear before the Committee. The decision of the Executive Committee following such review shall be final.

12.6.2 An AHP shall not have a right to the fair hearing and appeal procedures under these Bylaws.

12.6.3 An AHP is subject to automatic withdrawal of privileges upon loss of license by the authorizing state agency or loss of required physician sponsorship

ARTICLE 13

CLINICAL DEPARTMENTS

13.1 Organization.

13.1.1 Structure.

The Medical Staff shall be organized in the following clinical departments:

Surgery and Medicine. Surgery includes general surgery and all sub-specialties thereof, anesthesia, pathology, obstetrics and gynecology, orthopedics, and podiatry. Medicine includes internal medicine and all sub-specialties thereof (including gastroenterology and oncology), emergency medicine, pediatrics, radiology, and family medicine.

13.1.2 Changes in Departments.

Departments and Sections may be added, eliminated, divided or combined upon recommendation of the MEC with the approval of the Governing Board.

13.2 Responsibility of Departments.

13.2.1 Responsibility.

The Departments shall:

(a) Recommend the types of data to be collected to implement and conduct ongoing evaluation of professional practices in the Department in accordance with the Ongoing Professional Practices Evaluation Policy.

(b) Develop a procedures list, establish criteria for the granting of Clinical Privileges applicable to the Department and recommend same to the MEC.

(c) Develop an emergency call coverage roster and submit such roster to the Office of Medical Staff Services as prescribed by the Board following consultation with the MEC.

(d) Establish criteria for and implement mechanisms for focused review consistent with the Focused Professional Practice Evaluation policy.

(e) Develop Department rules and regulations.

(f) Develop recommendations for continuing medical education.

(g) Monitor adherence to Bylaws and other Governance Documents, including, without limitation, medical records completion requirements.

13.3 Assignment to Clinical Departments.

13.3.1 Assignment.

Each member of the Medical Staff 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.

13.3.2 Meetings.

Each member will be allowed to vote in only one Department and to represent only one Department on committees (including the MEC),

13.4 Department Chair.

13.4.1 Qualifications.

Each Department Chair shall be a Member of the Active Staff, qualified by training, experience, and demonstrated ability for the position. He shall have demonstrated professional ability in at least one of the clinical sections covered by the Department. The Department Chair shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

13.4.2 Selection of Chairman.

The Department Chair shall be elected by vote of the Active Staff Members of the applicable Department from qualified nominees submitted in writing by Department members, subject to meeting the above stated qualifications.

13.4.3 Terms of Office.

The Department Chair shall serve a two-year term beginning on the first day of the Medical Staff Year following his selection. The Department Chair is eligible to succeed himself. The Department Chair 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 Chair, the MEC will then appoint a Department member to serve as the Chair for the remainder of the term.

13.4.4 Removal of Department Chair.

Removal of a Department Chair for cause may be initiated upon the recommendation of the MEC, or two-thirds (2/3) majority vote of the Active Staff members of the Department. Removal will be effected by a majority vote of Active Staff members of the Department and approval by the Board. Grounds for removal for cause shall be the same as removal of Medical Staff officers.

13.5 Responsibilities, Duties, and Authority of Department Chair.

Each Chair shall:

13.5.1 Account to the MEC for all clinically and administratively related activities of the Department.

13.5.2 Consistent with Governance Documents, oversee the implementation of Peer Review activity in the Department.

13.5.3 Recommend to the MEC criteria for Clinical Privileges that are relevant to the services provided in the Department consistent with determinations for same made in the Department.

13.5.4 Recommend Clinical Privileges for each member of the Department.

13.5.5 Develop and implement programs for orientation of new members.

13.5.6 Assess and recommend to the relevant hospital authority off-site sources for needed patient care treatment and services not provided by the Hospital.

13.5.7 Enforce the Medical Staff Bylaws, Rules and Regulations, and policies, and the Department rules and regulations and help integrate the Department into the primary functions of the organization.

13.5.8 Actively support and enforce requirements that all Department members to complete adequately and in a timely manner the medical records of their discharged patients (within the period required by these Bylaws, Rules and Regulations and by any regulatory agency).

13.5.9 Verify that Focused Professional Practice Evaluations are completed and evaluate results for staff members 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 MEC.

13.5.10 Participate in the ongoing assessment and improvement of the services, treatments, and quality of care provided in the Department.

13.5.11 Cause Department rules and regulations relating to standards of patient care to be developed, approved, implemented, and reviewed at least annually for any needed revision.

13.5.12 Cause all standing orders of Practitioners to be reviewed initially, on change, and periodically (*e.g., annually*), if the responsibility is not assigned to a standing committee of the Medical Staff (*e.g., Pharmacy and Therapeutics Committee*).

13.5.13 Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the MEC, CEO, or the Governing Board.

13.5.14 Promote CME activity in the Department.

13.5.15 Determine the qualifications of and make recommendations for Allied Health Professionals seeking to provide or performing specified services in the Department.

13.5.16 Coordinate and integrate inter-Department and intra-Department services.

13.5.17 Recommend space and other resources needed by the Department or service.

13.5.18 Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services.

13.5.19 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 Board.

ARTICLE 14

OFFICERS OF THE MEDICAL STAFF

14.1 Officers.

14.1.1 Officers.

Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff and Treasurer.

14.1.2 Qualifications.

Officers shall be members of the Active Staff at the time of their nomination and election and shall remain in good professional and ethical standing during their term of office. Each candidate for a Medical Staff Officer position shall attest that he or she has read the Governance Documents and will enforce them in his or her position, if elected.

No officer of the Medical Staff shall concurrently hold more than one office on the Medical Staff, serve as a Department Chair, or serve as an at-large representative to the Executive Committee.

14.2 Nomination and Election of Officers.

14.2.1 Nominations for officers may be made in the following ways:

(a) By nomination from an ad hoc Nominating Committee appointed by the MEC for this purpose.

(b) By petition. Nominating by petition shall require the signature of at least ten (10%) percent of the Active Staff members and each petition shall be filed with the Medical Staff Services office at least thirty (30) days prior to the scheduled election. The Medical Staff shall be notified of these additional nominees at the time the roster of candidates is finalized, which shall be at least two weeks prior to the election.

(c) The nomination of the individual serving as Vice Chief of Staff to Chief of Staff shall be automatic.

14.2.2 There will be no nominations from the floor on the day of the election.

14.2.3 If, before the election, any individual nominated for an office shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the final Medical Staff meeting of the Year.

14.2.4 Roster of Candidates and Ballot.

A ballot of candidates for each of the officer positions shall be finalized and the roster of candidates made available to the Medical Staff two weeks prior to the election. Written ballots shall be made available at the Medical Staff meeting at which the election will be conducted.

14.2.5 Election procedures.

Officers shall be elected by a majority vote of the Active Staff Members present at a general meeting of the Medical Staff meeting at which there is a quorum. Unless otherwise determined, elections shall be scheduled for the Annual Meeting of the medical staff. 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. All voting will be by secret written ballot. Voting by proxy shall not be permitted.

14.2.6 Absentee Ballots

Active Staff Members who are unable to attend the meeting at which officers will be elected may submit to the Medical Staff Services office a written request for absentee ballot at least five (5) days prior to such meeting. Absentee ballots shall be returned to the Medical Staff office not later than twenty-four (24) hours prior to the meeting. Absentee ballots completed and timely returned shall be counted in the vote during the meeting.

14.3 Term of Office/Vacancies.

14.3.1 Term of Office.

Officers shall each serve a two-year term, beginning the first day of the Medical Staff Year 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.

14.3.2 Vacancies in Office.

Vacancies in office during the Medical Staff Year, except for the 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 office of Immediate Past Chief of Staff will not be filled.

14.4 Removal of Elected Officers From Office.

14.4.1 Removal.

Removal of a Medical Staff officer for cause may be accomplished by a two-thirds (2/3) majority vote of the Active Medical Staff at a meeting of the Medical Staff.

14.4.2 Grounds for Removal.

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) removal or suspension from the Medical Staff.

(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 professional liability insurance in the level and manner required by the Board.

(g) failure to maintain Active Staff membership.

(h) exclusion from the Medicare/Medicaid programs.

14.4.3 Automatic removal.

An officer shall be automatically removed from his position upon loss of Medical Staff membership or professional license.

14.5 Administrative Pay

Administrative pay may be given to the Chief of Staff, Vice Chief of Staff, and Department Chairs and source of payment from Medical Staff Funds. Approval of amount and terms by both the Executive Committee and the Board is required. The administrative pay may be changed or terminated at any time upon approval by both the Executive Committee and the Board.

14.6 Responsibilities, Duties and Authority of Officers.

14.6.1 Chief of Staff.

The responsibilities, duties, and authority of the Chief of Staff are to:

(a) call, preside at, and determine the agenda of all general and special meetings of the Medical Staff.

(b) serve as chairman of the MEC, with tie-breaking vote prerogative only, and as ex officio member of all other Medical Staff committees without vote.

(c) enforce Medical Staff Bylaws, Rules and Regulations and other rules as reflected in the Governance Documents; implement sanctions when they are indicated; and enforce the Medical Staff's compliance with procedural safeguards in all instances in which disciplinary action has been requested or initiated against a Practitioner.

(d) appoint the Chair and all Medical Staff members of Medical Staff standing and ad hoc committees, except the MEC; appoint the Medical Staff members of Hospital and Governing Board committees when these are not designated by position or by specific direction of the Governing Board.

(e) represent the views, policies, concerns, needs, and grievances of the Medical Staff to the Governing Board and administration; serve ex officio as a non-voting member of the Governing Board.

(f) advise the Governing Board on the effectiveness of Peer Review activity and the overall quality of patient care in the Hospital.

(g) advise the Governing Board, 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 position needs.

(h) serve as spokesman for the Medical Staff in its external professional and public relations, when requested to do so by the CEO or the Board.

14.6.2 Vice Chief of Staff.

The responsibilities, duties, and authority of the Vice Chief of Staff are to:

(a) assume the responsibilities, duties, and authority of the Chief of Staff during the latter's absence, whether the absence is temporary or permanent.

(b) serve as a voting member of the MEC.

(c) serve as Chair of the Performance Improvement Committee.

(d) be automatically nominated for the Office of Chief of Staff at the next election.

(e) assure maintenance of accurate and complete minutes of all Medical Staff meetings.

(f) give proper notice of all Medical Staff meetings on order of the Chief of Staff.

(g) take steps so that an answer is rendered to all official Medical Staff correspondence.

(h) serve as Chair of the Bylaws Committee.

14.6.3 Immediate Past Chief of Staff.

The responsibilities, duties, and authority of the Immediate Past Chief of Staff are to:

(a) serve as a voting member of the MEC.

(b) advise the Chief of Staff and MEC on matters concerning the Medical Staff.

(c) perform other functions at the request of the Chief of Staff, CEO or the Board.

(d) assume the responsibilities, duties, and authority of the Chief of Staff when both the latter and the Vice Chief of Staff are temporarily absent.

(e) serve as Chair of the Credentials Committee.

14.6.4 Treasurer.

The responsibilities, duties, and authority of the Treasurer are to:

(a) serve as a member of the Executive Committee;

(b) maintain a record of medical staff dues, collections, and accounts;

(c) be responsible for the preparation of financial statements

(d) authorize Medical Staff Fund expenditures and sign checks pursuant to his authority

ARTICLE 15

COMMITTEE STRUCTURE

15.1 There shall be a Medical Executive Committee and the following standing committees: , Performance Improvement and Patient Safety Committee, Peer Review Committee, Practitioner Health Committee, Utilization Management Committee, and Pharmacy and Therapeutics Committee.

15.2 Committees are intended to reflect the membership of the Medical Staff and each member of the Medical Staff shall have an obligation to participate in committee functions as may be requested by the Chief of Staff from time to time.

15.3 The MEC and every standing committee shall have the authority to form *ad hoc* committees to carry out specific tasks, which in turn shall be considered Medical Staff committees. Membership terms on committees shall be for the duration of the committee's purpose, but no term shall be longer than two years.

15.4 All committees shall report and make recommendations to the MEC.

15.5 All committees shall meet at least quarterly unless otherwise required by these Bylaws or requested by the Chief of Staff or Chair of the Committee. Committees shall keep minutes of meetings and submit minutes to the Chief of Staff.

15.6 All committees may, at the discretion of the Chair of the Committee, meet in executive session for all or part of a meeting. During executive session, only members of the committee shall be present, except for individual invited to present information for the benefit of the committee on the matters to be discussed in executive session and individuals providing support for the committee, such as minute takers.

ARTICLE 16

MEDICAL EXECUTIVE COMMITTEE

16.1 Role of the Medical Executive Committee.

The role of the MEC shall be to carry out responsibilities of Medical Staff and shall have authority to represent and act on behalf of the Medical Staff when the Medical Staff is not meeting as a whole. The MEC shall have primary responsibility for all activities related to self-governance of the Medical Staff and for oversight and continuing improvement of professional services rendered at the Hospital.

16.2 Composition of the Medical Executive Committee

The MEC shall be composed of the officers of the Medical Staff, Chair of each Department, the Physician Advisor, the Emergency Department Medical Director, the Hospitalist Medical Director, the OB/GYN Medical Director, and one at-large representative elected by the Medical Staff at large for a two-year term and the CEO, CNO, DCQI, and Director of Medical Staff Services shall serve as ex officio members. The process for electing the at large representative shall be the same process as that for electing officers. Active and Courtesy members of the Medical Staff shall be eligible for membership on the MEC as an at-large representative. The Chief of Staff shall serve as Chairman of the MEC.

16.3 Responsibilities of the MEC

The primary responsibilities of the MEC are to:

16.3.1 Before making a recommendation of appointment or reappointment, the committee shall considering evidence of i) challenges to licensure or registration, ii) voluntary and involuntary relinquishment of any license or registration, iii) voluntary and involuntary termination of Medical Staff membership, iv) voluntary and involuntary limitation, reduction or loss of clinical privileges, v) evidence of an unusual pattern or excessive number of professional liability actions, vi) the applicant's health status, morbidity and mortality data when available, relevant Practitioner specific data as compared to aggregate data when available; and vii) entry into an Order with any licensing Board whether public, non-public, private or non-disciplinary.

16.3.2 Using information obtained from focused and ongoing evaluation of professional services and practices to make credentialing decisions.

16.3.3 Considering whether there is sufficient clinical performance information to make a recommendation.

16.3.4 Verifying that recommendations relating to an individual Practitioner or AHP take into account information related to the general competencies of patient care, medical clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

16.3.5 Make recommendations to the Governing Board relating to the granting of Medical Staff membership and delineation of Clinical Privileges.

16.3.6 Be accountable to the Board for the quality of professional services rendered, including the organization and implementation of performance improvement activity.

16.3.7 Set, maintain and enforce standards for professional performance in the Hospital consistent with generally recognized evidence-based standards for patient care and safety.

16.3.8 Implement mechanisms to evaluate complaints relating to professional competence or conduct of members of the Medical Staff and initiate the disciplinary process, implement the fair hearing/appeal process when invoked, and make recommendations to the Board as to the disposition of complaints and the need for disciplinary action, including termination of Medical Staff membership.

16.3.9 Oversee the process for evaluation of Practitioners, including plans for conducting focused and ongoing evaluation of professional services and take reasonable steps to verify that it is implemented consistently and with the necessary frequency.

16.3.10 Request evaluations in instances where there is doubt about a Practitioner's ability to perform Privileges requested.

16.3.11 Review and make recommendations to the Board relating to the structure of the Medical Staff and the process used to review credentials and delineate Privileges.

16.3.12 Make recommendations to the Board relating to permission granted to AHPs to perform specified services, the types of AHPs qualified to provide specified services, and any conditions that should attach.

16.3.13 Appoint ad hoc committees to review and make recommendations to the MEC on specific matters.

16.3.14 Review and act on reports of all Medical Staff committees, Departments and ad hoc committees.

16.3.15 Receive and act on all Hospital reports, including reports related to utilization management, infection control, and case management.

16.3.16 Appoint an ad hoc committee to review and make recommendations with regard to Bylaws, Rules and Regulations and other Governance Documents.

16.3.17 Assist in obtaining and maintaining accreditation.

16.3.18 Review and act on matters relating to finances of the Medical Staff.

16.3.19 Review Hospital policies with regard to implications for the Medical Staff and make recommendations to the Board regarding the same.

16.3.20 Keep the Medical Staff as a whole informed of its activities and pertinent developments.

16.3.21 Have the authority to adopt Medical Staff policies in accordance with these Bylaws and to adopt such procedures and implementing details as may be reasonably necessary to carry out duly promulgated rules and regulations and Medical Staff policies effectively.

16.3.22 Where appropriate, delegate its authority to the relevant Department or committee.

16.3.23 Verifying that the Hospital has sufficient, space, equipment, staff and other necessary resources to support the Privileges requested.

16.3.24 Provisionally adopt an urgent amendment to the rules and regulations

16.3.25 Determines the qualifications of the radiology staff who use equipment and administer procedures

16.3.26 Approves the nuclear service's directors specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

16.4 Removal of MEC Members.

Except for removal of officers, which shall be handled in accordance with the provisions for removal of officers, a member of the MEC may be removed by two thirds (2/3) vote of the MEC for failure to carry out duties of office, neglect or loss or restriction of Medical Staff membership or clinical privileges.

16.5 Meeting.

The MEC shall meet as often as necessary to accomplish its functions, but at least 10 times per year.

16.6 Changes to the Authority, Composition and Duties of the MEC.

The authority and composition of and delegation of duties to or by the MEC may be changed by amendment to the Bylaws.

16.7 Resolution of Conflict.

In the event of conflict between the MEC and one or more members of the Medical Staff relating to matters of governance, including the development or amendment of a bylaw, regulation or policy, the Chief of Staff shall convene a meeting of representatives of the opposing parties and other individuals as may be indicated, including the Chief Executive Officer. The group shall make a good faith and reasonable effort to find consensus to the extent practicable, identify potential avenues of resolution and make a recommendation for resolution to the parties or to the Governing Board as may be applicable.

Individual members of the Medical Staff who are dissatisfied with the efforts at resolution or recommendation for resolution regarding a rule, regulation or policy, may communicate their position in writing directly to the Board, with a copy to the Chief of the Medical Staff, unless otherwise directed by the Board. Further direction shall be from the Board.

In the event of conflict between one or more members of the Medical Staff and the Governing Board, a process similar to that described in the first paragraph shall be followed: a meeting of the involved parties or representatives of the parties shall be convened (the latter appointed by the Chief of Staff and the Chairman of the Board); and a good faith and reasonable effort shall be made to gather the facts and find consensus to the extent practicable. A final determination shall be made by the Board taking into account the mission of the Hospital, the interests of patients and considerations of quality and safety.

This section shall not apply to matters relating to corrective action or implementation of hearing and appeal rights under these Bylaws.

ARTICLE 17

STANDING COMMITTEES OF THE MEDICAL STAFF

17.1 General.

There shall be five standing committees of the medical staff: the Performance Improvement and Patient Safety Committee, the Peer Review Committee, the Practitioner Health Committee, Utilization Management Committee, and the Pharmacy and Therapeutics Committee.

17.1.1 The members of each committee shall be appointed by the Chief of Staff unless otherwise expressly provided.

17.1.2 The term of an appointment shall be two years. The Chief of Staff may renew appointments without limitation.

17.1.3 The size of each committee shall be small enough to be manageable and reflect the breadth and diversity of the Medical Staff.

17.1.4 The Chief of Staff may remove a member of a standing committee during the term for cause.

17.2 Performance Improvement and Patient Safety Committee.

The role of the committee shall be to oversee Performance Improvement activity for the Medical Staff. The members of the Committee shall be composed of the Vice Chief of Staff, two members of the Medical Staff and *ex officio* representation from nursing, risk management, patient safety, Medical Staff Services, administration, and pharmacy.

17.2.1 The committee shall be responsible for:

(a) Receiving incident reports, patient complaints, or other matters relating to patient care and safety and delegate to appropriate committee or Department for action;

(b) Reviewing and making recommendation for analysis and improvement of patient satisfaction;

(c) Establishing mechanisms to respond effectively to actual occurrences and near misses , adverse events and sentinel events;

(d) Overseeing the development of orientation, ongoing training in patient safety for all staff;

(e) Overseeing development of patient safety material for patients/families;

(f) Conducting an annual survey of staff to collect data on opinions/perceptions of risks and suggestions for improvement. Assessing staff members' willingness to report errors;

(g) Conducting patient/family surveys to collect data on how organization can improve patient safety;

(h) Routinely reviewing patient safety data and identifying opportunities for improvement in processes and systems;

(i) Considering sentinel event and near-miss RCA information;

(j) Considering recommendations published in issues of Sentinel Event Alert when deciding which safety-related improvement projects to initiate;

(k) Reviewing and analyzing data. Applying information to development of appropriate corrective actions and process redesign;

(l) Initiating pro-active risk reduction strategies;

(m) Developing and implement strategies to sustain improvements;

(n) Developing an annual report to the Governing Board that addresses the scope, objectives, measures and effectiveness of the patient safety program

17.2.2 The committee shall communicate to the MEC the committee's findings and recommendations to improve performance and patient safety.

17.3 Peer Review Committee

The role of the committee shall be to oversee Peer Review activity for the Medical Staff. The members of the Committee shall be composed of the Chief of Staff, Physician Advisor, Department Chairs, ED Medical Director, two (2) members of the Medical Staff and ex-officio representation from nursing, Risk Manager/Patient Safety Officer, Quality Nurse, Medical Staff Services, and Administration. The Chair of the Peer Review Committee shall be the Chief of Staff.

17.3.1 The committee shall be responsible for:

(a) Participate in the collection, measurement and assessment of data that measures performance with respect to the following: medical assessment and treatment of patients; medication use and management; blood and blood product use; restraint use; seclusion use; behavior management and treatment; operative and other invasive procedures; resuscitation and its outcomes; the appropriateness of clinical practice patterns; and significant departures from established patterns of clinical practice. Sentinel event data and patient safety data shall be reviewed and incorporated into peer review and performance improvement activities;

(b) Identify a mechanism of case review selection utilizing criteria developed by the Clinical Departments and by the following entities: Risk Management, Utilization Review, Patient Safety, Infection Control and Clinical Quality Improvement. Such mechanism shall define the special circumstances requiring focused review and the time frames within which focused review activities can reasonably be adhered to;

(c) Identify members of the Peer Review Committee, or Medical Staff members in good standing, who qualify as a Specialty Peer, to conduct individual case reviews;

(d) Conduct individual case reviews where performance is questioned as a result of measurement and assessment activities

(e) Provide for participation in the review process by the individual whose performance is being reviewed;

(f) Identify cases to be reviewed by an outside entity. This shall include, but not be limited to, those cases in which an unbiased Specialty Peer

cannot be identified to review a specific case. The Peer Review Committee shall determine by discussion and vote, those cases to be reviewed outside of the Hospital;

(g) Collect data regarding individual, Specialty, and Departmental trends to enhance education, patient safety, and quality improvement;

(h) Report composite data to the Governing Board, Executive Committee, and Clinical Departments;

(i) Provide individual practitioner data to the Executive Committee for use in the reappointment process;

(j) Refer appropriate cases to the Clinical Department and/or Executive Committee to consider disciplinary action;

(k) Recommend implementation of changes to improve performance where indicated.

(l) Reviewing the policy for conducting evaluation of ongoing professional performance activity in the Departments and making recommendations with respect to the process and procedures used to conduct OPPEs. In this regard, the committee shall verify that there is ongoing assessment of the medical treatment of patients, medications, the use of blood and blood components, operative procedures, the appropriateness of clinical practice patterns, identification of significant departures from established patterns of clinical practice, the recommended criteria for autopsy, the evaluation of sentinel events in accordance with Hospital policy, and consideration of patient safety data.

(m) Reviewing the policy for conducting FPPEs and making recommendations with respect to the process and procedures for conducting FPPEs.

17.4 Practitioner Health Committee.

The role of the committee shall be to provide a forum for Practitioner health issues focusing on impairment by reason of alcohol or drugs, disability, and disruptive behavior. Responsibilities include the compilation of resources to provide professional assistance; formulation of protocols to respond to instances of impairment or inappropriate behavior; and provision of education about illness and impairment recognition. Membership shall consist of five members of the Medical Staff. The committee shall provide a mechanism to maintain the confidentiality of individuals seeking referral or referred for assistance. The Committee shall meet as often as necessary to accomplish its functions.

17.5 Utilization Management Committee.

The role of the committee shall be to evaluate the efficient and effective use of resources in the Hospital with particular emphasis on: i) length of stay; and ii) the medical necessity of admissions, the duration of stay and professional services furnished. There will be two (2) physicians one to include the Physician Advisor to provide vision and oversight. Additional physicians will be added as needed by the committee for peer review. Other committee members will include but not limited to CFO, CNO, Director of Case Management, Health Information Management, and Nursing services. The committee shall be responsible for:

(a) Compliance with applicable requirements of the utilization management plan
(b) Overseeing documentation that utilization management is applied regardless of payment source
(c) Monitoring under-utilization and over-utilization of resources and impact on quality of care
(d) Establishing protocols for external reviewers on site
(e) Ensuring maintenance of consistently valid, accurate, and complete medical record information to justify diagnoses, admissions, treatments, and continued care
(f) Ensuring the utilization review and management process is consistent with the utilization management plan and hospital policies
(g) Making medical necessity and appropriateness of care determinations independent of external review decision-makers,
(h) Providing peer review activities pursuant to the Medical Staff Policy on Peer Review Process and consistent with the Utilization Management Plan and goals
(i) Tracking, trending, and analyzing outlier cases to identify patterns
(j) Documenting in meeting minutes all extended stay reviews, including outcomes, rationale, and actions taken
(k) Acting as the appeal body for denials related to medical necessity of admissions, continued stays, and professional services.

17.6 Pharmacy and Therapeutics Committee

The role of the committee shall be to advise, educate, promote drug safety and monitor adverse drug reactions. The Pharmacy and Therapeutics Committee shall consist of at least one Medical Staff member, the Director of Pharmacy, and one representative each from Nursing Service and Hospital Management.

17.6.1 The Pharmacy and Therapeutics Committee Shall be responsible for:

(a) Reviewing the appropriateness of empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;
(b) Developing and recommending to the Executive Committee and the CEO procedures relating to the selection, distribution, handling, use, administration and monitoring of effects of drugs and diagnostic testing materials;
(c) Reviewing all reported adverse reactions to drugs administered;
(d) Maintaining a formulary or drug list; and
(e) Reviewing the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics for all areas of

patient care services in the Hospital; consulting with the Infection Control Committee in this process.

ARTICLE 18

MEETINGS

18.1 Regular Meetings of the Medical Staff.

A regular meeting of the Medical Staff shall be conducted at least once a year ("Annual Meeting"), but may be held more frequently. Elections for Medical Staff office shall be held at the Annual Meeting which shall be before the end of the Medical Staff Year. The Chief of Staff shall preside over regular meetings.

18.2 Special Meetings of the Medical Staff.

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee and shall be called when a request for a special meeting is made by the CEO, the Board or at least 25 percent of the members of the Medical Staff. No business shall be transacted at a special meeting except as specified in the notice. The Chief of Staff shall preside over special meetings or delegate such role to another officer of the Medical Staff.

18.3 Committee Meetings.

Unless otherwise specified in these Bylaws, standing committees of the Medical Staff shall meet at least four times a year. Ad hoc committees shall meet as frequently as called by the Chair of the applicable committee.

18.4 Department Meetings.

Departments shall meet at least semi-annually and such meetings shall be viewed as a committee of the organized Medical Staff to receive, review and consider Peer Review materials and to constitute Peer Review activity.

18.5 Notice.

18.5.1 Notice of the time, place and date of a Medical Staff meeting shall be sent to each member of the Medical Staff at the member's last known address by regular U.S. mail or electronically, at least 10 calendar days before the scheduled date of the meeting.

18.5.2 Notice of the time, place and date of a committee or Departmental meeting may be given verbally or in writing sent to each member of the committee or Department at the member's last known address by regular U.S. mail or electronically, at least 5 calendar days before the scheduled date of the meeting.

18.5.3 All written notices shall be deemed mailed, when sent electronically or deposited in the United States mail, postage prepaid, addressed to the member of the Medical Staff at the member's last known address.

18.5.4 Personal attendance at a meeting shall constitute a waiver of notice of the meeting.

18.6 Quorum.

18.6.1 The presence of 50 percent of the Members of the Active Medical Staff shall constitute a quorum for purposes of electing officers and amendment of these Bylaws. If a quorum is not present, ballots, to include material to be voted on, will be sent to voting members. No quorum is needed to transact any other business.

18.6.2 For purposes of conducting committee business, a quorum shall consist of the persons present and eligible to vote.

18.7 Voting.

Only members of the Medical Staff who are authorized to vote may vote at Medical Staff Meetings. Voting for officers of the Medical Staff and amendment of the Bylaws shall be by secret written ballot. All members of committees or departments may vote unless serving in an ex officio capacity.

18.8 Attendance Requirements.

18.8.1 Members of the Medical Staff are encouraged but not required to attend meetings of the special and general meetings of the Medical Staff.

18.8.2 Each member of a committee or Department is encouraged but not required to attend meetings of the committee or Department as the case may be.

18.9 Minutes.

Minutes of all Medical Staff meetings shall be prepared under the direction of the Vice Chief of Staff and shall include a record of attendance and the vote taken on each matter. Minutes of committee and departmental committees shall be prepared under the direction of the chair of the committee or Department as the case may be. All minutes of meetings shall include a brief summary of the matters discussed, including any actions taken or recommendations or determinations made.

18.10 Dues.

The Medical Executive Committee shall establish the amount of bi-annual dues, if any, for each category of the Medical Staff. Medical Staff dues shall be separately accounted for and shall be used for purposes of the Medical Staff, which may include payment of a stipend to the Chief of Staff and the retention of and representation by, independent legal counsel at the Medical Staff's sole expense.

ARTICLE 19

CONFIDENTIALITY AND IMMUNITY

19.1 Confidentiality of Information.

Records and proceedings of the Medical Staff, Departments, and committees, including information regarding any member of or applicant to the Medical Staff shall, to the fullest extent of the law, be confidential. Such confidential information shall only be disseminated where expressly required by law, or by express approval of the Medical Executive Committee, or pursuant to officially adopted policy of the Medical Staff, including the dissemination of information to other health care entities or third party payers relating to the ability and qualifications of a member of the Medical Staff.

19.2 Breach of Confidentiality.

Effective Peer Review activity, including the consideration of the qualification of an application for Medical Staff membership, the consideration of ongoing or focused professional practices evaluation, requires candor. Accordingly, any breach of the confidentiality of records, discussions and deliberations of the Medical Staff, including the communications and work of committees and Departments, that arises from Peer Review activity shall be deemed to be conduct disruptive to the operations of the Hospital and detrimental to the delivery of quality care, treatment and services. Any such breach of confidentiality shall be grounds for disciplinary action under these Bylaws.

19.3 Immunity.

Each representative of the Hospital and every member of the Medical Staff, acting in good faith, and in accordance with these Bylaws, shall be exempt to the fullest extent permitted by law, from liability to an applicant or a member of the Medical Staff, for damages or other relief for any action taken, or statements or recommendations made while acting within the scope of his duties in connection with: i) an application for Medical Staff privileges; ii) providing information to the Hospital regarding a Practitioner's conduct and competence; and iii) participation in Peer Review activity pursuant to these Bylaws.

ARTICLE 20

OHCA

The Hospital, together with its work force, all members of the Medical Staff, and Allied Health Practitioners and other non-Physician health care providers that provide health care services to patients at the Hospital, collectively “Hospital Staff”, constitutes an Organized Health Care Arrangement under the HIPAA privacy regulation. Accordingly, the Hospital and Hospital Staff shall issue a joint notice of privacy practices, and each member of the Hospital Staff shall abide by the terms of this joint notice with respect to protected health information received in connection with the delivery of health care services at the Hospital. The Hospital and Hospital staff may share protected health information with each other, as necessary to carry out treatment, payment or health care operations functions relating to the OCHA.

The Hospital may revise the OHCA’s joint notice of privacy practices in its reasonable discretion, upon thirty days notice of revision to the Medical Executive Committee (with a copy of the revised joint notice), unless the compliance date of the law necessitates a shorter notice period. The revised joint notice shall be effective and binding upon the end of the notice period unless objected to in writing by the Medical Executive Committee before the end of the notice period.

ARTICLE 21

AMENDMENT OF BYLAWS

These Bylaws shall be reviewed periodically by the MEC or an ad hoc committee appointed by the MEC for such purpose and amended as necessary to reflect current operations or requirements of accreditation bodies or regulatory enforcement authorities.

21.1 Mechanism for Amendment.

These Bylaws may be amended by:

21.1.1 an affirmative vote of the Medical Staff at a meeting following recommendation of the MEC; or

21.1.2 the Medical Staff directly upon 2/3 vote of the voting Medical Staff at a meeting of the Medical Staff at which there is a quorum; and

21.1.3 approval of the Board.

21.2 Effective Date of Amendment.

An amendment shall be effective following an affirmative vote of the Medical Staff and approval of the Board.

21.3 Communication of Text.

The text of all proposed amendments to the Bylaws shall be made available to the Medical Staff at least thirty (30) days before a meeting of the Medical Staff to vote on the proposed amendment. Similarly, a copy of the text of an amendment to be brought directly to the Medical Staff for approval shall be provided to the Medical Executive Committee at least 30 days before the meeting at which such proposed amendment will be voted upon. The text of all amendments adopted by the Medical Staff and approved by the Board shall be communicated to the Medical Staff promptly following the effective date.

21.4 No Unilateral Amendment.

Neither the Medical Staff nor the Board shall amend the Bylaws unilaterally.

21.5 Technical Amendment

The MEC shall have the authority to adopt such amendments to the Bylaws as are in its judgment strictly technical clarification, or renumbering, or necessary to correct punctuation, spelling or other grammar errors. After adoption, such amendments shall be communicated to the Medical Staff and to the Board. Technical amendments are effective immediately upon adoption but are subject to reversal by vote of the Board or by affirmative vote of the Medical Staff within 60 days of adoption

21.6 Conflict between Hospital Corporate Bylaws and Medical Staff Bylaws.

In the event of conflict between the Hospital's corporate bylaws and the Bylaws of the Medical Staff the former shall control.

ARTICLE 22

AMENDMENT OF RULES AND REGULATIONS

The Rules and Regulations of the Medical Staff shall be amended on a periodic basis to facilitate the efficient and effective operation of the Medical Staff and to implement these Bylaws as may be necessary. The Medical Staff delegates to the MEC the authority to adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws.

22.1 Mechanism for Amendment.

22.1.1 Process

The Rules and Regulations of the Medical staff may be amended by:

(a) Majority vote of the MEC at a meeting at which there is a quorum, after having given at least 30 days notice of the proposed amendment to the Medical Staff; or

(b) Affirmative vote of a majority of the Medical Staff at meeting at which there is quorum. Any member of the Medical Staff desiring to submit a proposed amendment of the Rules and Regulations directly to the Medical Staff for approval, shall submit a copy of the proposed amendment to the MEC at least 30 days in advance of the meeting. If passed, the proposed amendment shall be submitted directly to the Board for approval; and

(c) Approval by the Board.

22.1.2 Urgent Amendment

The MEC may provisionally adopt and submit to the Governing Board for provisional approval such amendments to the Rules and Regulations as may be necessary to comply with law or regulation. The provisional amendment shall be effective immediately upon provisional approval by the Board. The Medical Staff shall be given immediate notice of such provisional amendment and shall have the opportunity for retrospective review and comment on the provisional amendment. All comments from the Medical Staff shall be submitted to the MEC within 30 days of issuance of the notice. If there is no opposition to the provisional amendment, the MEC shall notify the Governing Board and the provisional approval shall be final. If there is opposition or other conflict regarding the provisional amendment, the conflict resolution process shall be invoked and a revised amendment may be submitted to the Governing Board for approval.

22.1.3 Board Approval Required

The Rules and Regulations of the Medical Staff shall be effective upon approval by the Board. Neither the Board nor the Medical Staff shall have authority to amend the Rules and Regulations unilaterally.

22.1.4 Technical Amendment

The MEC shall have the authority to adopt such amendments to the Rules and Regulations as are in its judgment strictly technical clarification, or renumbering, or necessary to correct punctuation, spelling or other grammar errors. After adoption, such amendments shall be communicated to the Medical Staff and to the Board. Technical amendments are effective immediately upon adoption but are subject to reversal by vote of the Board or by affirmative vote of the Medical Staff within 60 days of adoption

22.2 Other Medical Staff Governance Documents.

The development and revision of all Medical Staff Governance Documents other than the Bylaws and the Rules and Regulations of the Medical Staff may be developed or revised by the Medical Executive Committee pursuant to the following principles.

22.2.1 The purpose of the Medical Staff Governance Document shall be to address implementation of procedures identified in the Bylaws and Rules and Regulations.

22.2.2 Medical Staff Governance Documents, including policies, shall be consistent with these Bylaws and the Rules and Regulations of the Medical Staff.

22.2.3 The Medical Staff Governance Document shall be adopted and amended by majority vote of the MEC at a meeting at which there is a quorum.

22.2.4 There shall be timely advance communication to the Medical Staff as a whole of the intent to develop or revise Medical Staff Governance Documents and the proposed text of such Document.

22.2.5 The MEC may delegate responsibility to Committees and Departments to formulate and implement Medical Staff Governance Documents, including policies.

22.2.6 All Governance Documents, including medical staff policies, are subject to approval by the Board.

22.2.7 All approved Governance Documents shall be distributed to the Medical Staff.

22.2.8 The Medical Staff shall be bound by approved Governance Documents.

22.2.9 The Medical Staff may, by affirmative vote at a meeting at which a quorum is present, determine to propose a policy or an amendment to a policy or similar Governance Document directly to the Board for its approval. In such instance, a copy of the proposal shall be submitted to the MEC and made available to the Medical Staff for review at least thirty (30) days in advance of submitting the proposal to the Medical Staff for vote.

Upon adoption and approval of these bylaws, the Hospital and Medical Staff agree that they shall be binding upon the Medical Staff and the Hospital and any successor in interest to the Hospital.

Approved by the Medical Staff

By: _____
Ardra Davis-Tolbert, Chief of Staff

Date: 12/6/2023

Approved by the Board

By: _____
Frankie Denmark, Chair

Date: 12/21/2023