THE BYLAWS OF THE MEDICAL STAFF
OF
EAST COOPER MEDICAL CENTER
2023

PREAMBLE

East Cooper Medical Center, a Tenet Health System Facility, is a corporation organized under the laws of the State of South Carolina and its purpose is to serve as a general acute care Hospital providing patient care, education and research.

Recognizing that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and assume this responsibility, subject to the ultimate authority of the Hospital's Governing Board, the physicians of East Cooper Medical Center are organized in conformity with these Bylaws and the Medical Staff Rules and Regulations. These Medical Staff Bylaws, Rules and Regulations create a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence.

These Bylaws, Rules and Regulations were prepared for compliance, and are to be construed in conformity with applicable Hospital licensing laws, applicable accreditation guidelines and regulatory requirements; they do not constitute an express or implied contract between or among any individual, committee or entity, unless otherwise expressly determined by State law.

DEFINITIONS APPLICABLE TO ALL GOVERNANCE DOCUMENTS

Accredited Surgical Outpatient Setting: a surgical outpatient setting that is accredited by The Joint Commission or the Accreditation Association for Ambulatory Health Care, Inc. or the American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

Admitting privileges: the right to admit patients to the Hospital.

Advanced practitioners: are Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives.

Allied Health Professional ("AHP"): an individual, other than a licensed physician, permitted to apply for and perform specified procedures and services at the Hospital as listed in the Rules and Regulations, Section 10.9.

Alternate physicians: A physician who has made an arrangement to provide substitute coverage for a physician's practice and/or ER call in their absence. Such coverage would apply only to a planned absence.

Asynchronous, Store and Forward Technologies: transmission of the patient's medical information from an originating site to the physician at a distant site. Images must be specific to the patient's medical condition and of a quality appropriate for rendering or confirming a diagnosis or treatment plan. Asynchronous technology does not include telephone calls, images transmitted via facsimile machines or text messages. Photographs must be specific to the patient's medical condition and adequate for rendering or confirming a diagnosis or treatment plan.

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

Board Certification: certification by a medical specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery.

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

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

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

Chief of Staff ("COS"): 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.

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

Days: calendar days unless otherwise expressly provided.

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

Department: a grouping of members in accordance with their specialty or major practice interest as specified in these Bylaws, Rules and Regulations.

Department Chairperson: the Chairperson of a Department selected in accordance with the Bylaws.

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.

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.

Focused Professional Practice Evaluation ("FPPE"): a standard that was initiated and is reviewed by the Joint Commission and is a requirement for accreditation. FPPE is a process by which the Medical Staff will evaluate the privilege-specific competence of a physician. Focused review shall be conducted with respect to all provisional staff members and when new privileges are granted, and may be conducted when clinical activity is insufficient to evaluate a physician's ongoing professional competence, or when there is a particular question as to a physician's clinical competence. 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. FPPE information and results shall be forwarded to the Department and the Credentials Committee and may be utilized:

A. in the credentialing and re-credentialing of a Professional

B. in the decision to grant, deny or restrict Clinical Privileges

C. in determining whether to initiate or seek disciplinary action

D. for educational purposes

Good Standing: a Medical Staff Member who is not currently the subject of a restriction of membership or privileges.

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 Rules and Regulations which are subject to the joint approval of the Medical Staff and the Governing Board. The term "Governance Document" also includes policies approved by the Medical Executive Committee and subject to approval by the Governing Board to implement the processes described in the Bylaws where further guidance is indicated for clarity or efficiency of administration.

Governing Board or "Board": the Governing Body of the Hospital.

Harassment: includes, without limitation, A) unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature when: (i) submission to the conduct is made either explicitly or implicitly a term or condition of employment or advancement; or (ii) 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 B) 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.

Hospital: East Cooper Medical Center.

Hospital-Based physicians: physicians who hold clinical privileges pursuant to a contractual arrangement with the Hospital.

Impaired Physician: A provider who is unable to practice clinically with reasonable skill and safety because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs, including alcohol.

Investigation: a review process initiated by the MEC to determine whether to undertake 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 probe.

Medical Executive Committee ("MEC"): the Executive Committee of the Medical Staff that shall constitute the leadership of the Medical Staff as described in these Bylaws, Rules and Regulations.

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.

Medical Staff/Staff/Organized Medical Staff: the formal organization of physicians who may practice independently and who have been appointed to the Medical Staff pursuant to these

Bylaws, Rules and Regulations.

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

Medical Staff Year: the calendar year.

Member: a physician 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, Rules and Regulations.

Ongoing Professional Practice Evaluation ("OPPE"): a standard that was initiated and is reviewed by the Joint Commission and is a requirement for accreditation. OPPE is 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 physician'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.

Oral Surgeon: a Dentist who has received additional training in oral surgery and is certified as such by the American Board of Oral and Maxillofacial Surgery.

Patient Contact: a patient contact is defined as any: inpatient admission, outpatient admission requiring direct physician contact, consultation, or direct emergency room contact.

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, but is not limited to, credentialing activity, Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, quality assurance, performance improvement, utilization review and disciplinary action.

Physician: an individual who holds a current, unrestricted license as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) or podiatrist (D.P.M.) or oral surgeon (D.M.D. or D.D.S.) in this State 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.

Podiatrist: an individual who has a doctor of podiatric medicine or surgery degree and a current, unrestricted license to practice podiatry in this State and is certified as such by the American Board of Podiatric Surgery (ABPS).

Primary Specialty: an area of practice identified by the physician and recognized by a certification Board as an area of specialty.

Proctor: a physician with clinical privileges who is engaged in monitoring or evaluating the professional services of another physician and who is in the same or similar specialty as the physician whose performance is being monitored or evaluated.

Proctoring: in person, onsite observation for purposes of monitoring or evaluating practitioner's professional performance.

Prompt: five business days, unless otherwise expressly provided in these Bylaws, Rules and Regulations.

Rules and Regulations: the Medical Staff Rules and Regulations.

Section: subdivision of a clinical Department, grouping members in accordance with their specialty or major practice interest.

Section Chief: the member of the Active Medical Staff who is duly selected in accordance with the Bylaws, Rules and Regulations to serve as the Director of a Clinical Section.

State: South Carolina.

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

Telemedicine physician: telemedicine means the use by a physician of medical information exchanged from one site to another via electronic communications using i) Interactive Telecommunications Systems, and ii) Asynchronous, Store and Forward technologies. Any physician providing telemedicine services to inpatients and outpatients at the Hospital shall have an unrestricted license to practice medicine in this State.

ARTICLE 1

NAME

The name of this organization shall be the Medical Staff of East Cooper Medical Center.

ARTICLE 2

PURPOSE

SECTION 1: PURPOSE OF THE MEDICAL STAFF

2.1. The fundamental role of the Medical Staff is to:

2.1.1. provide care, treatment and services to patients, and to provide oversight for the quality of care, treatment and services rendered to patients at the Hospital by physicians with privileges, and to provide for safe and a uniform quality of patient care

2.1.2. establish a structure for and the rules of self-governance of the Medical Staff

2.1.3. provide a mechanism for effective communication and resolution of disputes between and among the Medical Staff, Hospital Administration and Governing Board

SECTION 2: THE FUNDAMENTAL ELEMENTS OF SELF-GOVERNANCE OF THE MEDICAL STAFF

2.2. The fundamental elements of self-governance are to:

2.2.1. establish the standards for Medical Staff membership and clinical privileges and provide for means to enforce them

2.2.2. identify and implement the mechanisms and criteria to be used to conduct Peer Review activity consistent with the responsibility to provide quality patient care, and consistent with accreditation requirements, State law, and participation in government funded health care programs

2.2.3. participate in the Hospital quality/performance improvement program by conducting objectively all required peer evaluation activities through Medical Staff and/or Department/Service review, specific (Committee) monitoring processes, and a comprehensive occurrence screening program

2.2.4. establish a process for the selection and removal of Medical Staff Officers

2.2.5. provide a process for adopting and implementing Governance Documents

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

ARTICLE 3

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

SECTION 1: CONDITIONS

3.1. Appointment to the Medical Staff and exercise of clinical privileges shall be conditioned upon the following:

3.1.1. Membership on the Medical Staff will be extended to physicians (M.D. / D.O.), oral surgeons (D.M.D. / D.D.S.), and podiatrists (D.P.M). A Medical Staff member shall continually meet the qualifications, requirements and duties of the Medical Staff set forth in the Bylaws, Rules and Regulations, and other Governance Documents.

3.1.2. A physician may only admit a patient or provide services to a patient if the physician is a member of the Medical Staff with clinical privileges as defined in these Bylaws, Rules and Regulations.

3.1.3. Physicians may practice only within the scope of privileges awarded.

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

3.1.5. There shall be no right to Medical Staff Membership or clinical privileges based solely on other affiliation.

3.1.6. The duration of appointment shall not exceed three years.

3.1.7. A physician 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 their clinical privileges and Medical Staff membership upon termination or expiration of the agreement, fair hearing rights under these Bylaws shall be deemed to have been waived and shall not apply.

3.1.8. The Hospital may determine as a matter of policy that certain physicians may be employed in accordance with a written contract between the Hospital and the physician. An employed physician must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category as any other member of the Medical Staff. Corrective action of an employed physician shall be handled in accordance with the provisions of the fair hearing and appellate review procedures of these Bylaws, unless otherwise expressly provided by the terms of the employment contract.

SECTION 2: ELIGIBILITY FOR MEMBERSHIP – EXCLUSION CRITERIA

3.2. No person shall be eligible for appointment to the Medical Staff who:

3.2.1 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

3.2.2 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

3.2.3 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

3.2.4 does not have all State and Federal controlled substance certificates, including DEA permits, required for exercise of privileges sought

3.2.5 has not successfully completed a medical residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or training equivalent per specialty, or who does not demonstrate current enrollment in good standing in such a program

3.2.6 does not meet the board certification requirements set forth in these Bylaws

3.2.7 does not provide proof of professional liability coverage with a qualified carrier of the type and in the amount required by these Bylaws that covers all privileges that would be requested

3.2.8 seeks to obtain privileges that are subject to an exclusive contractual arrangement or the Department to which the applicant would be assigned is closed

3.2.9 does not authorize the Credentials 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

SECTION 3: GENERAL REQUIREMENTS.

3.3. To obtain and maintain privileges a physician must continuously demonstrate and be able to document the following requirements for membership:

3.3.1. Current competence in general areas:

3.3.1.1. Patient Care (reflecting the expectation that the care will be compassionate, appropriate and effective according to circumstance)

3.3.1.2. Medical/Clinical Knowledge (reflecting the expectation that physicians will demonstrate appropriate levels of knowledge and the ability to apply that knowledge for the benefit of patients)

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

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

3.3.1.5. Professionalism (reflecting the expectation that physicians will conduct themselves professionally, ethically and responsibly and will demonstrate understanding and sensitivity to diversity)

3.3.1.6. Systems-based practice (reflecting the expectation that physicians will make an effort to understand Hospital systems, e.g., computerized medical record and ordering systems, and make a reasonable effort to work with them)

3.3.2. Appropriate training and experience for the clinical privileges sought.

3.3.3. Board certification in the applicant's primary specialty must be achieved within the specified timeframe as determined by the applicant's respective board. If a specialty board does not specify a timeframe for certification, the physician will have five (5) years from the time of completion of residency or fellowship training to obtain specialty board certification. Such certification must be maintained and in good standing while exercising privileges at the Hospital. Recertification shall be required in accordance with the rules of the applicable certification board.

Exemptions to these requirements are as follows:

3.3.3.1. Physicians who were appointed to the Medical Staff on or before February 1, 2004 and who have maintained uninterrupted clinical privileges at ECMC since that appointment are exempt from the requirement for any board certification.

3.3.3.2. Physicians who were appointed to the Medical Staff between February 1, 2004, and July 16, 2011, must maintain board certification but shall be exempt from the specific requirement of board certification in their primary specialty (the principal focus of the physician's practice at the Hospital).

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

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

3.3.6. 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.

3.3.7. That there is no physical or mental condition that interferes with the physician's ability to provide quality, safe care to patients and to exercise the clinical privileges requested with or without reasonable accommodation.

3.3.8. Each member of the Medical Staff must identify one or more alternate physician(s) who will provide backup coverage when necessary. The alternate physician(s) must be a member in good standing of the ECMC Medical Staff and shall have the same clinical privileges as the Medical Staff member for whom he is providing backup coverage.

3.3.9. Participation in and cooperation with Peer Review activity and maintaining the confidentiality of peer review proceedings.

3.3.10. Compliance with State and Federal requirements regarding billing for professional services.

3.3.11. Not participating in fee splitting or "ghost" surgical or medical care.

3.3.12. Preparation and completion of medical records and other documentation in a timely, legible, complete and accurate manner in compliance with all current Hospital policies, Bylaws, Rules and Regulations.

3.3.13. Compliance with requirements for conducting a medical history and physical examination ("H&P") [as specified here and in the current Hospital Bylaws, Rules and Regulations, and policies:]

3.3.13.1. 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. An anaesthesia H&P will be completed and documented in the medical record for each patient prior to a procedure requiring anaesthesia services. Refer to the Medical Staff Rules & Regulations, Article 2.

3.3.13.2. 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. Refer to the Medical Staff Rules & Regulations, Article 2.

3.3.13.3. The content of all H&Ps shall be in accordance with the requirements set forth in the Rules and Regulations, Article 2.

3.3.14. Timely and complete responses to inquiries regarding documentation from any Hospital Department or Medical Staff Committee.

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

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

3.3.17. The attempt to secure permission for 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.

3.3.18. Prompt notification to the Director of Medical Staff Services in the event of any change in or loss of professional liability insurance coverage, including tail coverage.

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

3.3.20. Compliance with patient privacy policies and all HIPAA requirements as set forth in the Rules and Regulations.

3.3.21. Timely completion of continuing medical education requirements as necessary for licensure.

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

3.3.23. Participation in emergency coverage for the Emergency Department as set forth in the Rules and Regulations.

SECTION 4: SPECIAL REQUIREMENTS

3.4. Notification. Each physician shall promptly notify the Director of Medical Staff Services in the event of:

3.4.1. an adverse license action in any jurisdiction

3.4.2. an adverse credentialing action at any Hospital

3.4.3. exclusion from the Medicare, Medicaid, Tricare or any government-funded health care program

3.4.4. the conviction of any felony or misdemeanor

3.4.5. the filing or service of any professional liability demand letter or lawsuit

3.4.6. the settlement of or judgment in any malpractice action regardless of the amount

3.4.7. voluntary surrender of privileges with any health care facility

3.4.8. entry into an Order with any licensing Board whether public, non public, disciplinary or non-disciplinary.

3.4.9. the initiation of formal action against the physician relating to the treatment of a patient, professional conduct, or professional competence of the physician 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

3.4.10. 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 physician's professional competence, professional conduct or billing practices

3.4.11. Waiver of Requirements for Medical Staff Membership. A requirement for Medical Staff membership may be waived by the Governing Board upon request of the MEC upon determination that a waiver in a particular instance is in the overriding best interest of patient care and the Hospital. Waivers must be the exception and must be undertaken rarely.

ARTICLE 4

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1: APPOINTMENT MECHANISM

4.1.1. All requests for staff membership applications shall be directed to the Chief Executive Officer or their designee. Once the membership application request has been received by Medical Staff Services, initial review will be performed for completeness, including primary verification of current license, relevant training, board certification, a criminal background check and querying the NPDB. If complete, the application request will be reviewed by the Department Chairperson and Credentials Committee. If it is determined that the individual meets the initial criteria for Medical Staff membership, a Medical Staff Application and a copy of the Bylaws, Rules and Regulations shall be furnished to the applicant. A decision not to provide an individual with an application on the grounds that threshold or eligibility criteria are not met, shall not give rise to hearing and appeal rights under these Bylaws.

4.1.2. An application will not be provided if, in addition to the exclusion criteria outlined in Section 2, the pre-application discloses any of the following:

4.1.2.1. any history of prior involuntary license suspension, restriction or revocation in any US jurisdiction

4.1.2.2. any history of prior involuntary DEA suspension, restriction or revocation in any US jurisdiction

4.1.2.3. any history of exclusions or debarment from any Federal or State healthcare program

SECTION 2: CONDITIONS AND DURATION OF APPOINTMENT AND REAPPOINTMENT

4.2. Initial appointment (including the provisional year) and reappointment to the Medical Staff shall be made by the Governing Board, upon the recommendation from the MEC, and shall be for a period up to, but not to exceed, three (3) years.

4.2.1. Every applicant for appointment and reappointment shall:

4.2.1.1. submit a completed application. Completed means the application has been signed on the forms prescribed with all information requested provided or an explanation as to why the information cannot be provided, together with supporting documentation as requested or an explanation as to why documentation cannot be provided.

4.2.1.2. notify the Director of Medial Staff Services promptly if information contained in the application has changed since submission of the application

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

4.2.1.4. authorize the Hospital to conduct a criminal background check.

4.2.1.5. authorize the Hospital to communicate with other Hospitals with which the applicant has been associated or which may have knowledge regarding applicant’s professional conduct and competence

4.2.1.6. authorize the release of relevant documents and information

4.2.1.7. 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 physician relating to professional competence or conduct

4.2.1.8. 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 physician's practice of medicine in the State, with limits of at least $1 Million per occurrence and $3 Million aggregate. If such professional liability coverage is at any time claims-made and coverage is canceled or non-renewed for any reason, the physician shall notify the Medical Staff Services office promptly and either:

4.2.1.8.1. 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

4.2.1.8.2. 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

4.2.1.9. document that no physical or mental health issue exists that would interfere with the exercise of clinical privileges requested

4.2.1.10. submit information relating to the voluntary or involuntary resignation from any Hospital or restriction of privileges, and notify the Hospital if physician fails to appeal any corrective action or disciplinary action at any other facility

4.2.1.11. acknowledge that they have read the Bylaws, Rules and Regulations and agrees to abide by them as well as with applicable policy

4.2.1.12. 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

4.2.1.13. agree to participate and appear for interviews upon request

4.2.1.14. submit an application fee in the amount established by the Medical Executive Committee

4.2.1.15. provide a current picture Hospital ID card or valid picture ID issued by a State or Federal agency to permit verification of identity

4.2.1.16. upon the MEC's request, sign a special release and authorization for any information related to Medical Staff membership

4.2.2. 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 the applicant meets all requirements for the privileges requested. The applicant shall have the burden of removing any doubt about their qualifications and credentials. A physician's failure to submit complete and accurate 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 incomplete or withdrawn shall not be considered a determination based on the conduct or

competence of the physician, and the return of the application shall not give rise to hearing and appeal rights under these Bylaws.

SECTION 3: PRE- APPLICATION PROCESS

4.3.1. 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:

4.3.1.1. the criteria specified in the Bylaws, Rules and Regulations to be eligible to be considered for initial Medical Staff membership or Allied Health Professional status, and

4.3.1.2. 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.

4.3.2. 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 Chairperson of the applicable Department, including all of the information and documents collected.

4.3.3. 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.

4.3.4. If an individual does not both meet the criteria to be eligible to be considered for membership, and 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 Credentials Committee documentation that demonstrates that the individual meets the criteria to receive an application. The decision of the Credentials Committee shall be final. A person who is refused an application because they are determined ineligible to receive one shall be deemed to have been declined an application for lack of eligibility and not denied an application for reasons relating to professional competence or conduct.

4.3.5. 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.

SECTION 4: INITIAL APPLICATION PROCESS

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

4.4.1. Initial review will be performed 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 physician'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 physician currently has privileges as well as physician-specific information resulting from Peer Review activity at the Hospital, including Focused and Ongoing Professional Practices Evaluation,

4.4.2. The Department Chairperson shall review the completed application within thirty (30) days following receipt of the completed application.

4.4.3. The Credentials Committee shall make a recommendation to the MEC as to Medical Staff membership and the clinical privileges to be awarded.

4.4.4. Within sixty (60) days following receipt of the recommendation of the Credentials Committee, provided that the application is complete, the MEC shall make a recommendation to the Governing Board as to Medical Staff membership and the clinical privileges to be awarded. The recommendations may be as follows:

4.4.4.1. Recommendation for appointment with clinical privileges requested.

4.4.4.2. Recommendation for appointment but not with all privileges requested.

4.4.4.3. Recommendation against appointment.

4.4.4.4. Rejection of application as incomplete.

4.4.5. If the MEC recommends that an application be denied in whole or in part, there shall be no further action by the Governing Board until the applicant's hearing and appeal rights are exhausted or waived. The applicant shall be promptly informed of the MEC's determination by the Chief of Staff and, if adverse to him, shall be given the reason[s] for the adverse recommendation and made aware of available fair hearing rights as established by these Bylaws.

4.4.6. 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 Governing Board's determination and the reasons therefor if the determination is adverse to the applicant. The Hospital will notify the applicant in writing of the Governing Board's final action within twenty (20) days after the date on which final action is taken.

4.4.7. The Director of Medical Staff Services shall report adverse determinations to the NPDB and State licensing agencies as required by law.

SECTION 5: PROVISIONAL STATUS FOR INITIAL APPOINTMENTS

4.5. 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 36 months if recommended by the Credentials Committee, the MEC and the Governing Board. Provisional staff members shall have the same rights and responsibilities as physicians in the respective categories who are not provisional

SECTION 6: DENIAL OF APPLICATION

4.6.1. If an applicant supplies information in the application that contains significant misrepresentations or omissions, this may be grounds for denial of the application, or if membership or privileges have been granted, for corrective action under these Bylaws.

4.6.2. The Hospital shall not accept a new application from a physician whose application for appointment was denied in the preceding three years for reasons relating to professional competence or conduct.

SECTION 7: REAPPOINTMENT

4.7.1. Each physician shall be provided 90 days advance notice that the term of appointment is expiring and that an application for reappointment must be completed and submitted within the prescribed timeframes. A physician who does not submit an application for reappointment within the required time frames shall be subject to a late fee and/or deemed to have resigned from the Medical Staff.

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

4.7.3. Information obtained from Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation, as well as other Peer Review activity, shall be factored into the determination to grant, deny, or modify the application for reappointment.

4.7.4. Participation in continuing education will be considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.

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

4.7.5.1. new privileges are awarded, regardless of whether the physician has already achieved full status as a member of the Medical Staff

4.7.5.2. clinical activity is insufficient to evaluate the ongoing clinical performance of a physician

4.7.5.3. questions about an individual physician's judgment, professional behavior, or competence arise

4.7.6. Where there has been a lack of activity, the Credentials Committee or MEC may recommend monitoring in the form of proctoring or other forms of focused practice evaluation such as retrospective record review.

4.7.7. If the MEC recommends that a reapplication be denied in whole or in part, there shall be no further action by the Governing Board until the applicant's hearing and appeal rights are exhausted or waived. The applicant shall be promptly informed of the determination and, if adverse to him, shall be given the reason[s] for the adverse recommendation and made aware of available fair hearing rights, and mediation, if required by applicable State statute. Applicants for reappointment may have existing appointments renewed for short, defined periods of time pending the duration of any hearing and appeal, but such reappointment shall not constitute a judgment with regard to the matter under review.

SECTION 8: LEAVE OF ABSENCE

4.8.1. A physician 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. 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 Governing Board.

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

4.8.3. Failure to request reinstatement within one year, 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 physician shall be submitted and processed as in the case of a new application.

SECTION 9: RESIGNATION FROM THE MEDICAL STAFF

4.9 Any physician who desires to resign from the Medical Staff must submit a letter of resignation, through the assigned Department Chairperson, to the MEC and the CEO.

The letter of resignation must indicate who will fulfill any outstanding Emergency Department Call obligations. The physician's subsequent application for Medical Staff membership or clinical privileges will not be processed if there are any unfulfilled obligations under these Bylaws or the Rules and Regulations, including, but not limited to, the need to complete delinquent medical records. Subsequent application for staff membership or clinical privileges will not be processed while outstanding obligations remain, and this status will be reported in response to any requests for references.

SECTION 10: MAINTENANCE OF PEER REVIEW MATERIALS

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

4.10.2. 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 physician'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.

ARTICLE 5

CATEGORIES OF THE MEDICAL STAFF

SECTION 1: MEDICAL STAFF OBLIGATIONS AND PREROGATIVES

5.1. The Medical Staff shall be divided into the following categories: Active, Associate, Courtesy, Consulting, and Honorary.

5.1.1. Active Medical Staff.

5.1.1.1. A member of the Active Medical Staff shall:

5.1.1.1.1. meet all conditions and requirements for Medical Staff membership as outlined in Articles 3 and 4

5.1.1.1.2. meet the criteria for core privileges in the Department in which the applicant is applying

5.1.1.1.3. engage in a minimum number of 24 patient contacts per 12-month period at the Hospital for the initial provisional appointment

5.1.1.1.4. engage in a minimum number of 72 patient contacts per 36 month period at the Hospital for reappointment

5.1.1.1.5. participate in Peer Review activity as requested

5.1.1.1.6. participate in the on-call roster for the Emergency Department as requested by the Medical Director of the Emergency

Department. Members who have been Active Staff for a continuous period of ten (10) years and have reached the age of sixty (60) years are not required to participate in the on-call roster for the Emergency Department.

5.1.1.1.7. have the right to admit and attend patients

5.1.1.1.8. have the right to attend and vote at all meetings

5.1.1.1.9. have the right to hold office

5.1.1.2. Hospital-based physicians (eg. Pathologists) who do not admit patients may be members of the Active Medical Staff if they meet the requirements for membership as outlined in Articles 3 and 4.

5.1.2. Courtesy Medical Staff.

5.1.2.1. A member of the Courtesy Medical Staff shall:

5.1.2.1.1. meet all conditions and requirements for Medical Staff membership as outlined in Articles 3 and 4

5.1.2.1.2. be a member of the Active staff of another Hospital or, for those applicants applying for surgical privileges, operate in an accredited surgical outpatient setting in which their regular participation in ongoing peer review and performance improvement activities is documented and their performance evaluated

5.1.2.1.3. meet the criteria for core privileges in the Department for which the applicant is applying

5.1.2.1.4. participate in Peer Review activity as requested

5.1.2.1.5. not engage in more than 24 patient contacts per 12-month period at the Hospital for the initial provisional appointment

5.1.2.1.6. not engage in more than 72 patient contacts per 36 month period at the Hospital for reappointment

5.1.2.1.7. not have the right to vote at, but may attend, Quarterly Medical Staff Meetings or Department Meetings

5.1.2.1.8. have the right to participate in the on-call roster for the Emergency Department, if desired

5.1.2.1.9. have the right to hold office only in clinical sections

5.1.2.2. If the physician exceeds 24 patient contacts in the 12-month provisional period, or 72 patient contacts in a 36 month reappointment period at the Hospital, the physician will be advanced to the Active Medical Staff

5.1.3. Associate Medical Staff.

5.1.3.1. A member of the Associate Medical Staff shall:

5.1.3.1.1. meet all conditions and requirements for Medical Staff membership as outlined in Articles 3 and 4

5.1.3.1.2. meet all criteria for core privileges of their Department except the minimum required number, if any, of admissions, procedures, patient management requirements, etc.

5.1.3.1.3. not be entitled to surgical privileges or privileges to perform invasive procedures. Physicians granted surgical clinical privileges prior to November 7, 2007 shall be permitted to maintain these privileges in accordance with the criteria set forth below.

5.1.3.1.4. undergo 100% chart review

5.1.3.1.5. be advanced to the Active Medical Staff if the physician exceeds 24 patient contacts in the 12-month provisional period at the Hospital, or 72 patient contacts in a 36 month reappointment period at the Hospital

5.1.3.1.6. be placed on the Courtesy Staff if Active privileges are obtained at another Hospital

5.1.3.1.7. not be eligible to vote at, but may attend, Quarterly Medical Staff or Departmental meetings

5.1.3.1.8. be permitted to hold office only in clinical sections

5.1.3.1.9. participate in peer review activities as required

5.1.4. Consulting Medical Staff.

5.1.4.1. A member of the Consulting Medical Staff shall:

5.1.4.1.1. meet all conditions and requirements for Medical Staff membership as outlined in Articles 3 and 4

5.1.4.1.2. not have the right to hold office

5.1.4.1.3. not be permitted to take part in the emergency room call schedule

5.1.4.1.4. not be permitted to vote at, but may attend, Quarterly Medical Staff or Departmental meetings

5.1.4.1.5. generally provide expertise in a specialty or subspecialty that is not otherwise available through Active or Courtesy membership

5.1.4.1.6. not be permitted to admit patients but can provide consultative services to patients at the request of Active, Associate or Courtesy staff physicians

5.1.4.1.7. not function as primary surgeon but can assist the primary surgeon

5.1.4.1.8. be able to provide unlimited consultations without the requirement of advancement to Active staff

5.1.5. Honorary Medical Staff.

5.1.5.1. The Honorary Staff is intended for physicians who do not practice at the Hospital but who wish to maintain an affiliation with the Hospital. The Honorary Staff shall consist of distinguished physicians and retired members of the Medical Staff in Good Standing. Physicians will be nominated to the Honorary Staff and approved on a unanimous vote by the MEC. A member of the Honorary Staff may:

5.1.5.1.1. receive notices of and attend Medical Staff meetings

5.1.5.1.2. not have the right to vote or hold office

5.1.5.1.3. not have the right to admit or treat patients at the Hospital.

SECTION 2: CHANGE IN MEMBERSHIP OR STAFF CATEGORY

5.2. A staff member may, at any time, request a change of staff Category or Department affiliation by submitting a Staff Category Change Request Form to the Medical Staff Office. If the applicant meets the requirements outlined in these Bylaws, Delineation of Privileges, and on the Staff Category Change Request Form, the request will be forwarded to the Department Chairperson and the Credentials Committee. The Credentials Committee will make a recommendation to the MEC, and the MEC will forward their recommendation to the Governing Board for final approval. After final approval, the Medical Staff Office will notify the physician of the final decision.

ARTICLE 6

CLINICAL PRIVILEGES

SECTION 1: EXERCISE OF PRIVILEGES

6.1. Every physician providing direct clinical services at this Hospital, by virtue of membership or otherwise, shall, in connection with such practice, be entitled to exercise only those privileges specifically granted to him by the Governing Board. Each Department shall delineate the privileges that may be exercised in the Department and identify the criteria to be used in extending such privileges. The privileges must be within the scope of the license authorizing the physician to practice in this State.

Regardless of the privileges granted, each physician must obtain consultation when necessary for the safety of their patients or when required by these Bylaws, Rules and Regulations and other policies of the Medical Staff and the Hospital.

SECTION 2: DELINEATION OF CLINICAL PRIVILEGES

6.2.1. Application. Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Telemedicine physicians must submit an application for telemedicine privileges. Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a physician for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

6.2.2. Basis For Privilege Determination. The determination to grant a request for specific clinical privileges shall be based on evidence of current competence and appropriate training and are designed to assure the Medical Staff and Governing Board that patients will receive quality care, treatment, and services. 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 Evaluation, Ongoing Professional Practice Evaluation, 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. Medical Staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

6.2.3. Procedure. All requests for clinical privileges shall be processed pursuant to the procedures outlined in Articles 3 and 4 for Medical Staff membership.

SECTION 3: CLINICAL PRIVILEGES

6.3.1. A Practitioner may only exercise the clinical privileges granted.

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

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

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

SECTION 4: THE MECHANISM FOR EVALUATING AND GRANTING NEW PRIVILEGES

6.4.1. An applicant 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.

6.4.2. All new privileges shall be subject to Departmental, MEC and Governing Board approval prior to being granted.

6.4.3. 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 Chief of Staff in consultation with the Department Chairperson and Credentials Committee. The FPPE process for new privileges shall not constitute an investigation.

SECTION 5: UNAVAILABLE CLINICAL PRIVILEGES

6.5. Notwithstanding any other provisions of these Bylaws, Rules and Regulations to the extent that any requested clinical privilege is not available at the Hospital (whether because of exclusive contract, lack of facilities, policy decision of the Governing Board, or otherwise), the request shall be rejected without the necessity of further processing. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the hearing and appeal rights under these Bylaws.

SECTION 6: TEMPORARY PRIVILEGES

6.6. General

6.6.1. There is no right to temporary privileges.

6.6.1.1. Any temporary privileges shall be granted by the CEO or their designee following recommendation from the Department Chairperson or Chief of Staff or designee.

6.6.1.2. 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, and no previous adverse action with respect to license or clinical privileges.

6.6.2. Qualifications for temporary privileges.

6.6.2.1. Prior to temporary privileges being granted, the Medical Staff Office must receive all application requirements and primary verification. The application for temporary privileges must have been approved by the Clinical Department Chairperson, Credentials Committee, MEC, and is awaiting approval by the Governing Board. By applying for temporary privileges, all physicians agree to be bound by the Medical Staff Bylaws, Rules and Regulations, Departmental Rules and Regulations and applicable Hospital policies.

6.6.3. Authority to Grant temporary privileges / Conditions.

6.6.3.1. The CEO or their designee, with the concurrence of the Chairperson of the applicable Department or in their absence, the Chief of Staff, may grant temporary privileges under the circumstances noted below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed one hundred twenty (120) days. The physician will automatically lose those temporary privileges unless an extension is granted through a written request by the physician to the Credentials Committee for a specific reason. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

6.6.4. There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable are:

6.6.4.1. to fulfill an important patient care , treatment or service need

6.6.4.2. when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the Governing Board. “Applicant for new privileges” includes an individual applying for clinical privileges for the first time or an individual currently holding clinical privileges who is requesting one or more additional privileges.

6.6.5. Denial, Termination or Restriction of temporary privileges.

6.6.5.1. Temporary privileges, unless acted upon pursuant to other provisions of these Bylaws or Rules and Regulations shall terminate automatically at the end of one hundred twenty (120) days or the specific period for which they were granted, without the hearing and appeal rights under these Bylaws. The CEO, Chief of Staff or Department Chairperson or their designees may terminate or restrict temporary privileges in the event of the discovery of questionable qualifications/ability or false information provided by the physician, or when the life or health of a patient could be endangered by the treatment by that physician or for similar reasons. The reason for the decision to withdraw temporary privileges shall be communicated to the affected Practitioner in writing and shall be effective immediately. No physician is entitled to the hearing and appeal rights set forth in these Bylaws for the denial, nonrenewal, restriction or termination of temporary privileges based on the physician’s professional conduct or competence. In the event a physician’s temporary privileges are terminated or restricted, the physician’s patients then in the Hospital shall be assigned to another physician by the Department Chairperson responsible for supervision or by the Chief of Staff. The wishes of the patient shall be considered, when feasible, in assigning a substitute physician.

SECTION 7: EMERGENCY PRIVILEGES

6.7.1. Privileges. In an emergency, any physician to the degree permitted by their license shall be permitted to do everything deemed by that physician reasonably necessary and appropriate to save the life or limb of a patient. The CEO and Chief of Staff shall be notified promptly in such cases.

6.7.2. Conclusion of Emergency. When the emergency no longer exists, the physician must request the privileges necessary to continue to treat the patient if he so desires. In the event such privileges are denied or there is no desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

6.7.3. Definition of Emergency. For the purpose of this Section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life or limb of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

SECTION 8: DISASTER PRIVILEGES

6.8.1. Disaster privileges may be granted to an eligible physician and/or AHP volunteer by the CEO or designee with consultation from the Chief of Staff when:

6.8.1.1. the Emergency Management Plan is activated

6.8.1.2. the Hospital is unable to meet immediate patient needs

6.8.2. The person requesting disaster privileges must provide:

6.8.2.1. a valid government-issued ID and one of the following:

6.8.2.1.1. picture Hospital ID card that clearly identifies professional designation

6.8.2.1.2. current license to practice

6.8.2.1.3. 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

6.8.2.1.4. identification indicating that the individual has been granted authority to render patient care, treatment and services in an emergency by a government agency

6.8.2.1.5. identification by a current member of the Medical Staff who has personal knowledge about the individual's ability to act as a licensed independent physician and/or AHP during an emergency

6.8.2.2. Primary source verification of credentials shall subsequently be completed within 72 hours. If more time is required, the Hospital shall document:

6.8.2.2.1. the reason(s) this could not be performed within 72 hours of the practitioner's arrival

6.8.2.2.2. evidence of the licensed independent practitioner's and/or AHP's evidence of demonstrated ability to continue to provide adequate care, treatment, and services, and evidence of the Hospital's attempt to perform primary source verification as soon as possible

6.8.3. The Chief of Staff shall arrange for direct observation, if necessary, or clinical record review of each person exercising disaster privileges.

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

6.8.5. The CEO (or their designee), with the concurrence of the Chief of Staff, shall decide within 72 hours of granting disaster privileges to an eligible physician and/or AHP 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.

6.8.6. Disaster privileges shall terminate automatically when the emergency has subsided or when the eligible physician and/or AHP volunteer's services are no longer required. Termination of disaster privileges shall not give rise to hearing and appeal rights under these Bylaws.

SECTION 9: MODIFICATION OF CLINICAL PRIVILEGES

6.9. A physician may request modification of their clinical privileges. Such request shall be in writing. A request for new privileges shall be handled in the same manner as for a new applicant.

SECTION 10: TELEMEDICINE PRIVILEGES

6.10.1. Definitions.

6.10.1.1. Originating Site: site where the patient is located at time the service is performed.

6.10.1.2. Distant Site: site where the physician providing the professional service is located.

6.10.2. The Department of Radiology shall recommend services that may be provided by telemedicine link. The final delineation of telemedicine privileges shall be subject to MEC and Governing Board approval.

6.10.3. No physician may provide telemedicine services without having been granted clinical privileges to do so.

6.10.4. The MEC shall recommend which clinical services are appropriately delivered via telemedicine link following consultation with the relevant Departments. Such services are subject to approval by the Governing Board.

6.10.5. All Distant Site Practitioners seeking to provide telemedicine services to Hospital patients shall complete an application for appointment. The Medical Staff and the Governing Board shall process an application for telemedicine Privileges through one of the following three mechanisms:

6.10.5.1. The Distant Site Practitioner must fully credentialed and privileged in accordance with the procedures set forth in Article 4 of these Bylaws.

6.10.5.2. The Medical Staff and the Governing Board use credentialing information from the Distant Site to make a privileging decision. The Medical Staff and the Governing Board may utilize the Distant Site's credentialing information only if (i) the Distant Site is a Joint Commission-accredited organization and (ii) the Distant Site Practitioner is licensed in the State of South Carolina, where the patient is located.

6.10.5.3. The Medical Staff and the Governing Board rely on the credentialing information and the privileging decision of the Distant Site. The Medical Staff and the Governing Board may utilize this mechanism only if the following conditions are met:

6.10.5.3.1. 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

6.10.5.3.2. The Practitioner is privileged at the Distant Site for the services they seek to provide at the Hospital

6.10.5.3.3. The Distant Site Practitioner is licensed by the State in which the patient is located

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

6.10.5.3.5. The Distant Site's privileging and credentialing processes comply with the applicable Medicare Conditions of Participation

6.10.6. All Practitioners exercising telemedicine privileges at the Hospital shall be subject to Peer Review activity, including OPPE and FPPE in accordance with these Bylaws, Rules and Regulations, and policies. In the case of a Distant Site Practitioner, the Hospital will also 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 Committee at the Distant Site. 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 from patients, members of the Medical Staff, and Hospital Staff. All sharing of information between the Hospital

and the Distant Site will be in compliance with State and Federal regulations to protect the confidentiality of Peer Review information and patient protected health information.

6.10.7. All individuals exercising telemedicine privileges at the Hospital shall:

6.10.7.1. have a current and unrestricted license to practiced medicine in the State unless State law expressly permits otherwise and the Governing Board so approves

6.10.7.2. provide proof of liability insurance and tail coverage in the type, amount and duration required in these Bylaws, Rules and Regulations

6.10.8. 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.

ARTICLE 7

EVALUATION OF MEDICAL STAFF MEMBER CONDUCT OR PERFORMANCE

SECTION 1: BASIS AND PURPOSE FOR INVESTIGATION

7.1.1. An investigation may be undertaken whenever the conduct or performance of any Medical Staff member is alleged to:

7.1.1.1. compromise or may compromise patient care or safety

7.1.1.2. present a question as to the Member's competence, judgment, ethics, qualifications, ability to work cooperatively with others, physical or mental health

7.1.1.3. violate their obligations as a member of the Medical Staff or any of the duties and responsibilities imposed pursuant to the Governance Documents

7.1.1.4. act in a manner detrimental to the operations of the Hospital

7.1.1.2 being suspected of, or being observed to be, acting in a manner consistent with an impaired physician

7.1.2. The purpose of the investigation would be to evaluate the need for corrective action that may be disciplinary or educational/remedial in nature.

SECTION 2. MECHANISM FOR INITIATING AN INVESTIGATION

7.2. All requests for investigation shall be submitted to the MEC through the Chief of Staff, and shall set forth the specific conduct constituting the basis for the matter. A request for investigation may be brought by the Clinical Department Chairperson or by the CEO or their designee, or as a report or recommendation from the Peer

Review Committee. The MEC may also determine a need for investigation of its own initiative.

SECTION 3. INVESTIGATION

7.3.1. The MEC may reject a request for investigation as unfounded and determine that no action is necessary.

7.3.2. The MEC may refer the matter to the Peer Review Committee for review and recommendations with a report to be given to the MEC within 30 days.

7.3.3. Otherwise, the MEC shall conduct such investigation as it deems necessary to determine if disciplinary action should be undertaken.

7.3.4. An investigation can include informal interviews with the requesting party and the Affected Physician (each out of the presence of the other and each without the presence of legal counsel).

7.3.5. The MEC or the Peer Review Committee may also request interviews with or reports from other persons including external consultants, Departmental review, and chart reviews, if applicable.

7.3.6. 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 to external review undertaken in connection with Focused Professional Practice Evaluation.

7.3.7. Neither the investigation nor any other activities of the MEC in acting upon a request for review shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these Bylaws shall apply during the investigation.

7.3.8. In the event the Affected Physician resigns their 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.

SECTION 4. TIME FOR TAKING ACTION; NOTICE; RIGHT TO HEARING

7.4. Within thirty (30) days after receipt of the request for investigation or within such reasonable additional time as the MEC deems necessary, the MEC shall take action on the complaint as a result of its investigation. Within five (5) days after taking action, the MEC shall give written notice to the Affected Physician stating which of the actions set forth in this Article 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.

SECTION 5. POSSIBLE ACTIONS

7.5. After investigation, the MEC may:

7.5.1. close the matter without action

7.5.2. issue a letter of warning or reprimand or initiate Focused Professional Practice Evaluation

7.5.3. recommend terms of probation or mandatory co-admitting or consultation requirement

7.5.4. recommend reduction, suspension, or revocation of clinical privileges

7.5.5. recommend that an already imposed summary suspension of membership or clinical privileges be terminated, modified, or sustained

7.5.6. recommend that the physician's membership be suspended or revoked

7.5.7. take or recommend other actions deemed by the MEC to be reasonable and appropriate under the circumstances. The MEC may impose summary suspension if the facts gathered during the investigation demonstrate that grounds for summary suspension are present.

SECTION 6. NOTICE TO CEO

7.6. The Chief of Staff of the MEC shall notify the CEO of any investigation resulting in the need for disciplinary or restrictive action.

SECTION 7. FINALITY OF ACTION

7.7.1. An MEC decision to close a request for investigation, issue a warning or reprimand, or refer a physician for Focused Professional Practice Evaluation shall be final and without recourse to hearing and appeal rights under these Bylaws, Rules and Regulations.

7.7.2. An MEC decision to take any other action shall be in the form of a recommendation to the Governing Board. The Governing Board shall act on the recommendation following exercise of fair hearing rights and appeals by physician unless such rights are waived in writing.

SECTION 8. USE OF MEMBERSHIP/PRIVILEGES

7.8. The Affected Physician shall retain the use of their Medical Staff membership and right to exercise clinical privileges pending final action on the request for investigation by the Governing Board unless such Membership and/or privileges are otherwise suspended as provided in this Article.

SECTION 9. SUMMARY SUSPENSION OR SUMMARY RESTRICTION

7.9.1. Grounds/Authority. All or any portion of a physician'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. This could include any physician suspected of being an "impaired physician". The following persons shall be authorized to take summary action: Chief of Staff, the Chairperson of a Clinical Department, or the CEO following consultation

with the Chief of Staff or the Chairperson of the Clinical Department. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the MEC.

7.9.2. 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:

7.9.2.1. of their right to an informal interview with the MEC

7.9.2.2. whether the action is reportable pursuant to any State or Federal statute

7.9.2.3. that the MEC may take action to terminate, modify or continue the suspension within 29 days.

7.9.2.4. that even if the suspension or restriction is terminated when the MEC convenes to review the action, the physician will be entitled to a hearing at which the sole issue will be whether there was a reasonable factual basis for the summary suspension or restriction.

7.9.2.5. a copy of the notice shall promptly be delivered to the CEO, the MEC and the Governing Board

7.9.3. 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 their 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; these activities shall be informal, without legal counsel, and none of the fair hearing rights under the Bylaws shall apply. In the event the affected Practitioner resigns their 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.

7.9.4. 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 whether the MEC continues, terminates or modifies the summary suspension, it shall also decide whether to recommend adverse action against the physician’s Medical Staff membership and clinical privileges. The MEC shall promptly give written notice of its determination to the suspended

physician, the CEO and the person or body who imposed the suspension or restriction (if other than the MEC).

7.9.5. Right to Hearing. Following the decision of the MEC regarding further action, the fair hearing/appeal rights shall apply.

SECTION 10: AUTOMATIC SUSPENSION

7.10.1. The following (7.10.2. – 7.10.13) shall result in the automatic suspension or revocation of clinical privileges or be deemed a voluntary resignation from the Medical Staff and shall not entitle the Affected Physician to the fair hearing and appeal rights specified in the Bylaws or Rules and Regulations, unless otherwise expressly provided.

7.10.1.1. Failure to Complete Medical Records. Suspension shall be imposed pursuant to Medical Staff 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 60 days of suspension shall be deemed to constitute a voluntary resignation from the Medical Staff and the voluntary relinquishment of all Clinical Privileges. Any resumption of clinical privileges shall require a new application which shall be processed in the same manner as a new application.

7.10.1.1.1. Accumulation of more than three (3) medical record suspensions in any consecutive twelve (12)-month period shall result in a fine of $500 payable to the ECMC Medical Staff Fund and a referral to the Peer Review Committee.

7.10.1.1.2. The suspension may be terminated by the Chief of Staff if it is determined that failure to timely complete the records at issue was justified (i.e. illness, or other circumstance beyond the control of the affected practitioner.)

7.10.1.2. Licensure. Whenever a physician'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 physician'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 their 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 Credentials and Medical Executive Committees, upon petition of the physician, and to the approval of the Governing Board.

7.10.1.3. Drugs/Medication. Upon receipt by the Hospital of notice that a physician'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 physician's ability to prescribe controlled substances in the Hospital. Whenever a physician's DEA registration expires, the physician's right to prescribe medications shall be automatically suspended until the DEA registration is renewed. Fair hearing and appeal rights shall not apply.

7.10.1.4. Loss of Malpractice Insurance. If a physician fails to maintain professional liability insurance, including tail coverage, in the amounts as required by these Bylaws, Rules and Regulations, or fails to provide evidence of such coverage upon request of the CEO or their designee, the physician's membership and clinical privileges, shall be automatically suspended and shall remain so suspended until the physician 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. Fair hearing and appeal rights shall not apply.

7.10.1.5. Felony Conviction. A physician who has been convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically suspended effective immediately, regardless of whether an appeal is filed. The suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the MEC and action by the Governing Board. Fair hearing and appeal rights shall not apply. The suspension is a permanent administrative action.

7.10.1.6. Suspension, Exclusion, Debarment or Sanction by any Federal or State Health Care Agency. A physician who has been excluded 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 suspended. The suspension shall become effective immediately upon such debarment, sanction, conviction or listing regardless of whether an appeal is filed and shall remain in effect unless and until the individual is reinstated by subsequent recommendation by the MEC and action by the Governing Board. Fair hearing and appeal rights shall not apply.

7.10.1.7. Loss of Board Certification. If the physician fails to obtain or maintain board certification or board eligibility as required by these Bylaws, Rules and Regulations and by the applicable certification board, the physician will be deemed to have voluntarily resigned from the Medical Staff. Notwithstanding the foregoing, a physician may continue to be granted membership in the Medical Staff if the Governing Board, following recommendation by the MEC, determines in its sole discretion that there is an urgent need for physician services in the specialty to maintain the Hospital's complement of necessary

services and that the Hospital has exercised reasonable diligence under the circumstances to secure the necessary coverage by another Physician holding board certification. Fair hearing and appeal rights shall not apply.

7.10.2. The CEO shall impose the automatic action contemplated under this section following reasonable inquiry and affording the Affected Physician a reasonable opportunity to respond before action is taken.

7.10.3. The Affected Physician 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.

SECTION 11: ALTERNATE PATIENT COVERAGE

7.11. Immediately upon the imposition of a suspension, termination, restriction or revocation of clinical privileges, the Chief of Staff or responsible Department Chairperson shall ensure that alternate medical coverage is provided for the patients of the subject physician by a member of the Medical Staff if the physician'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.

ARTICLE 8

FAIR HEARING AND APPEAL PROCEDURES

SECTION 1: GENERAL PROVISIONS; DEFINITIONS; SETTLEMENT

8.1.1. Duty to Exhaust Remedies. Fair hearing and appeal procedures shall be exhausted before attempting to obtain judicial relief related to any issue or decision that may be subject to fair hearing and appeal. The absence of an interlocutory appeal process for reviewing any alleged violation of the Bylaws, Rules and Regulations or the Affected Physician's fair procedure rights does not warrant judicial intervention.

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

8.1.2.1. Adverse Action: an action or recommendation by the MEC that is grounds for fair hearing

8.1.2.2. Affected Physician: the Medical Staff member or applicant for membership with respect to whom any of the actions specified below has been taken or recommended, and whose membership or privileges may be affected thereby

8.1.2.3. Notice: means a written communication delivered personally to the Affected Physician 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 their address as it appears in the records of the Hospital. Copies shall be as effective as the original for the purpose of giving notice

8.1.2.4. 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

8.1.3. Settlements. At any time following receipt of notice of a recommendation or action which would entitle a physician to request a hearing under this Article, the physician and the MEC may discuss voluntary settlement or resolution of the matter. Upon such request and subject to the Affected Physician'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 Affected Physician; 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 settlement is not feasible. If the Affected Physician and the MEC reach a written agreement that could settle the matter, the Chief of Staff shall promptly notify the CEO and the Governing Board. Any such settlement shall be final only upon approval by the Governing Board.

SECTION 2: GROUNDS FOR HEARING

8.2. Except as otherwise provided in these Bylaws, Rules and Regulations, the taking or recommending of any one or more of the following actions shall constitute grounds for requesting a hearing:

8.2.1. Denial of initial appointment to the Medical Staff

8.2.2. Denial of staff reappointment

8.2.3. Suspension of staff membership or clinical privileges

8.2.4. Revocation of staff membership or clinical privileges

8.2.5. Denial or limitation of clinical privileges, including denial of temporary privileges for reasons relating to competence or conduct

8.2.6. Reduction in clinical privileges

8.2.7. Summary suspension of clinical privileges for more than fourteen (14) consecutive days

8.2.8. Mandatory consultation, proctoring or co-admitting requirements when the consultant, proctor or co-admitter has the authority to intervene

SECTION 3: NOTICE OF ADVERSE ACTION OR RECOMMENDED ACTION; REQUEST FOR HEARING

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

8.3.1. The notice shall:

8.3.1.1. describe what action has been taken or recommended

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

8.3.1.3. advise the physician that they have the right to request a hearing and that such request must be in writing and received by the Chief of Staff within thirty (30) days after the Date of Receipt of the Notice or such right will be waived

8.3.1.4. summarize the Affected Physician's rights in the hearing and enclose a current copy of the Medical Staff Bylaws

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

8.3.2. The Affected Physician 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 Chief of Staff. Failure of the Affected Physician to request a hearing as required shall be deemed to constitute a waiver of all hearing and appeal rights under these Bylaws and acceptance of the action described in the notice. The matter shall thereupon be forwarded to the Governing Board for final disposition. The Chief of Staff shall give notice to all parties of any such waiver and acceptance.

SECTION 4: TIME AND PLACE OF HEARING

8.4.1. Upon receipt of a proper request for hearing, the Chief of Staff shall promptly schedule a date for such hearing, and give notice to the parties of the time, place, and date thereof.

8.4.2. The hearing shall commence not more than sixty (60) days from the Date of Receipt of the request for a hearing by the Chief of Staff, except that when the request is received from a Member who is under suspension, the hearing shall commence as soon as reasonably practicable, but not later than forty (40) days from the date of receipt by the Chief of Staff of the request for hearing, unless a later date is agreed to by all parties. In such instances where the Member is under suspension, the notice of hearing shall be provided within a reasonable time prior to the date of commencement of the hearing and 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.

SECTION 5: STATEMENT OF CHARGES

8.5. As a part of, or together with, the Notice of Hearing, the MEC shall state the acts or omissions with which the Affected Physician 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 Physician, the Hearing Officer, and each party. If the Affected Physician promptly gives written request to the MRC, they 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.

SECTION 6: MEDICAL REVIEW COMMITTEE ("MRC") APPOINTMENT, REMOVAL, AND QUALIFICATIONS

8.6. 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 chairperson. If available, at least one member of the MRC shall have practice experience, education and training the same or sufficiently similar to the practice area of the Affected Physician 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 Physician. The Chief of Staff shall be authorized to appoint individuals to serve on the MRC who are not members of the Medical Staff if deemed necessary or if there is not a sufficient number of Medical Staff Members available or if there is not a member with similar education, training, and experience. The Chief of Staff shall provide the Affected Physician with notice of the members of the MRC, and the Affected Physician shall have the right to challenge the appointment of any member of the MRC by providing the Chief of Staff written notice of their objections. Any objections must be submitted to the Chief of Staff at least twenty (20) days prior to the date of the hearing. The Chief of Staff shall make the final determination on the appointment of the MRC. 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.

SECTION 7: HEARING OFFICER; CHAIRPERSON OF MRC

8.7. 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 they shall not be entitled to vote. The CEO shall provide the Affected Physician with notice of the Hearing Officer appointment. The Affected Physician shall have the right to challenge the Hearing Officer appointment by providing the CEO written notice of their objections at least twenty (20) days prior to the date of the hearing. The CEO shall make the final determination on the appointment of the Hearing Officer.

SECTION 8: POSTPONEMENTS AND EXTENSIONS

8.8. After the appointment of the MRC and before the commencement of the hearing, postponements beyond the times required by these Bylaws may be requested by any of the parties, and may be 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.

SECTION 9: MEDICAL STAFF REPRESENTATIVE

8.9. After a hearing has been properly requested, the Chief of Staff or their designee shall serve as Medical Staff representative to present the case on behalf of, and otherwise represent, the MEC.

SECTION 10: HEARING PROCEDURES

8.10.1. Pre-hearing Exchange of Information.

8.10.1.1. The rules of discovery shall not apply.

8.10.1.2. 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.

8.10.2. It shall be the duty of the Affected Physician and the MEC to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural irregularity or any objection to the MRC 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.

8.10.3. Failure to Appear. Failure of the Affected Physician to appear at the hearing shall be deemed to constitute the Affected Physician'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 Physician or their representative.

8.10.4. Representation. The Affected Physician and the MEC are entitled to be accompanied by and represented at the hearing by counsel.

8.10.5. 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

charges associated with any transcript that it requests. There shall be no other record of hearing testimony.

8.10.6. 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.

8.10.7. 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.

SECTION 11: HEARING RIGHTS

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

8.11.1.1. question and challenge the impartiality of the MRC members and the Hearing Officer. The Hearing Officer shall determine the procedure to exercise such right and any challenges shall be ruled upon by the Hearing Officer

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

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

8.11.1.4. introduce relevant documentary evidence

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

8.11.1.6. submit a written statement at the close of the presentation of evidence

8.11.2. Upon completion of the hearing, all parties shall receive a written decision of the MRC, including a statement of the basis for the decision within fifteen (15) days.

SECTION 12: CONDUCT OF THE HEARING

8.12. Generally, the hearing shall be conducted as follows:

8.12.1. The Medical Staff representative or counsel for the Medical Staff shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if they choose, the salient general conclusions the representative expects to prove.

8.12.2. 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.

8.12.3. At the close of the Medical Staff representative's case, the Affected Physician or their representative shall present an opening statement and shall make a case presentation of evidence and testimony. Any person, including an opposing party who is present, may be called in support of the case.

8.12.4. 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.

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

8.12.6. 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.

8.12.7. Upon the submission of any 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.

8.12.8. Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the Hearing Officer after consultation with the MRC regarding such matters shall be final.

8.12.9. 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 Physician 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 their testimony or other evidence, with copies thereof to the other parties.

8.12.10. 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.

SECTION 13: BURDEN OF PROOF

8.13. A physician who is challenging an adverse action or recommendation shall have the burden of proving, by clear and convincing evidence, that the recommendation or action in issue is not supported by the evidence, or is arbitrary, capricious or in violation of these Bylaws, Rules and Regulations, or other Governance Documents.

SECTION 14: DECISION AND REPORT OF MRC; NOTICE

8.14. Within fifteen (15) days after adjournment of the hearing, the MRC shall deliberate and render and deliver to the MEC and 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.

SECTION 15: GOVERNING BOARD ACTION AFTER MRC DECISION

8.15. 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.

SECTION 16: APPEAL TO GOVERNING BOARD

8.16.1. Time for Requesting Appeal. Within fifteen (15) days after receipt of the decision of the MRC, either the Affected Physician 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 other parties. The request shall set forth the ground(s) for appeal. If an appeal is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.

8.16.2. 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, deliberations, review of any further recommendations, and a final decision. The Governing Board shall have the option to allow each party or their representatives to appear personally before the Governing Board. The Governing Board shall give great weight to the MRC decision, and shall not act arbitrarily or capriciously. The Governing Board may however, exercise its independent judgment in determining whether a

Affected Physician 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.

8.16.3. Grounds for Appeal. The grounds for appeal are limited to:

8.16.3.1. substantial and prejudicial failure of the MRC to comply with these Bylaws, Rules and Regulations or other Governance Documents or to afford a fair hearing

8.16.3.2. the action or recommendation that prompted the hearing, or any substantial part was unreasonable, arbitrary or capricious

8.16.3.3. the MRC's decision or any substantial part was clearly contrary to the weight of the evidence

8.16.4. Notice of Time, Date, Place of Appellate Review Meeting. The Governing Board shall, within fifteen (15) 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 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 Chairperson of the Governing Board for good cause.

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

8.16.5.1. The Governing Board shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written briefs submitted by the parties. The Hospital shall provide the Governing Board, at the Hospital's expense, a transcript of the hearing. The Affected Physician 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.

8.16.5.2. The Governing Board may, in its sole discretion, appoint a Hearing Officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the Governing Board as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision.

8.16.5.3. Each party shall have the right to submit a written brief in support of their 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.

8.16.5.4. At the sole discretion of the Governing Board, each party and/or the parties' representative may be allowed the opportunity to appear personally and make oral arguments at the appellate review meeting. If a personal appearance is allowed, the parties and representatives present shall answer any questions posed by any member of the Governing Board.

8.16.5.5. 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.

8.16.5.6. At the conclusion of the appellate review, the Governing Board shall, at a time convenient to itself, but generally within fifteen (15) 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.

8.16.5.7. 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 or Rules and Regulations, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair.

8.16.5.8. 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 Chairperson of the Governing Board (or Hearing Officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such Chairperson (or the hearing officer), leave the meeting. Unless directed otherwise for

good cause by the Chairperson (or the Hearing Officer), the meeting shall proceed in the absence of such excluded person.

8.16.6. 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:

8.16.6.1. Within fifteen (15) 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.

8.16.6.2. 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 thirty (30) days after the receipt of the referral from the Governing Board. Within thirty (30) days after receipt of such recommendation, the Governing Board shall render its final decision.

8.16.6.3. 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 Physician, the Chief of Staff, the CEO, and each party, in person or by mail.

SECTION 17: RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

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

SECTION 18: RESIGNATION OR WITHDRAWAL OF APPLICATION

8.18.1. Notwithstanding any other provision of these Bylaws, whenever the Affected Physician unconditionally resigns from the Medical Staff, or resigns and relinquishes the privileges that are the subject matter of a hearing, or withdraws the application that is the subject matter of the hearing, or amends an application or request with regard to the items that are the subject matter of the hearing, or consents in writing to the action or recommendation that prompted the hearing, and if there are no other issues before the hearing, then all hearing and appeal proceedings with respect to the Affected Physician, their privileges or application, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent.

8.18.2. 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 Physician, 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.

SECTION 19: CONFIDENTIALITY

8.19. 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 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.

SECTION 20: REPORTING

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

SECTION 21: DISSEMINATION OF ADVERSE PRIVILEGING DECISIONS

8.21. The Hospital shall disseminate the final decision to deny, revoke or revise Hospital privileges to the Clinical Department Chairperson, Chief of Staff, and appropriate internal personnel such as the Director of the Operating Room, the Director of Nursing, and the Director of Ambulatory Surgical Services.

SECTION 22: EXCEPTIONS TO HEARING AND APPEAL RIGHTS

8.22. 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:

8.22.1. Closed Departments/Exclusive Contracts. The hearing and appeal rights under these Bylaws shall not be available to a physician whose application for Medical Staff membership and privileges is denied on the basis that the privileges they seek are granted only pursuant to a closed staff or exclusive use policy.

8.22.2. Medico-Administrative physician. 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 physician's contract with the Hospital. In the event of any conflict between the provisions of the contract and these Bylaws, the contract shall control.

8.22.3. Automatic Suspension or Termination of privileges. Unless otherwise expressly provided the hearing and appeal rights under these Bylaws are not available to a physician whose Medical Staff membership or clinical privileges are automatically suspended or terminated.

8.22.4. 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, Rules and Regulations.

8.22.5. 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 if required by the Medical Director of Emergency Services. Fair hearing and appeal rights shall not be available for any action or recommendation affecting a physician's duty to serve on emergency room call panel rosters.

8.22.6. 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.

8.22.7. 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, Rules and Regulations.

8.22.8. 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 their application.

8.22.9. 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 or Rules and Regulations.

8.22.10. 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.

8.22.11. 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.

8.22.12. 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, Rules and Regulations.

8.22.13. Termination of Appointment or Reappointment in Accordance with Practitioner's Contract with the Hospital. When a Practitioner provides professional services as an independent contractor, directly or indirectly pursuant to a contract with the Hospital, and their 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, Rules and Regulations.

8.22.14. Failure to advance from a provisional to regular staff category for reasons related to insufficient patient contacts.

ARTICLE 9

OFFICERS OF THE MEDICAL STAFF

SECTION 1: OFFICERS

9.1. Officers of the Medical Staff shall be the:

9.1.1. Chief of Staff by election of Active members of Medical Staff

9.1.2. Vice Chief of Staff by election of Active members of Medical Staff

9.1.3. Immediate Past Chief of Staff

9.1.4. Secretary-Treasurer by appointment of Chief of Staff

SECTION 2: QUALIFICATIONS

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

SECTION 3: NOMINATION AND ELECTION OF OFFICERS

9.3.1. The Chief of Staff and Vice-Chief of Staff shall be elected for a two (2) year term at the first quarterly Medical Staff meeting of the designated Medical Staff year. Election shall be by oral vote or showing of hands unless two (2) or more eligible voters request ballots. The candidate must be elected by a majority vote of the Active staff members present at the meeting as long as a quorum is met. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted. If a quorum is not present the election will be held via electronic means.

9.3.2. Nominations may be made in the following ways:

9.3.2.1. By nomination of the MEC.

9.3.2.2. The nomination of the individual serving as Vice Chief of Staff shall be automatic.

9.3.3.3. There can be nominations from the floor on the day of the election.

SECTION 4: TERM OF OFFICE/VACANCIES

9.4.1. Term of Office. Each Officer shall 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 their term or until a successor is elected, unless they shall sooner resign or be removed from office.

9.4.2. Vacancies in Office. The MEC shall fill vacancies in office during the Medical Staff term, except for the Chief of Staff. 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.

SECTION 5: REMOVAL OF ELECTED OFFICERS FROM OFFICE

9.5.1. Removal. Removal of a Medical Staff Officer may be initiated by a two-thirds (2/3) majority vote of the MEC and confirmed by 2/3 majority vote of the Active Medical Staff.

9.5.1.1. Grounds for Removal: Each of the following conditions in itself constitutes cause for removal of a Staff Officer from office:

9.5.1.1.1. Failure to perform the required duties of the office

9.5.1.1.2. Failure to adhere to professional ethics

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

9.5.2. Automatic Removal. An Officer shall be automatically removed from their position upon:

9.5.2.1.1. loss of Medical Staff membership or professional license.

9.5.2.1.2. revocation of professional license by the authorizing State agency

9.5.2.1.3. suspension from the Medical Staff

9.5.2.1.4. failure to maintain adequate professional liability insurance

9.5.2.1.5. failure to maintain Active staff membership

SECTION 6: RESPONSIBILITIES, DUTIES, AND AUTHORITY OF OFFICERS

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

9.6.1.1. call, preside at, and determine the agenda of all general and special meetings of the Medical Staff and the MEC

9.6.1.2. serve as Chairperson of the MEC with tie-breaking vote prerogative only

9.6.1.3. appoint the Chairperson 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

9.6.1.4 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 as a representative of the MEC

9.6.1.5. advise the Governing Board on the effectiveness of the quality/performance improvement program and the overall quality of patient care in the Hospital

9.6.1.6. advise the Governing Board, Administration, and the MEC on 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.

9.6.1.7 serve as spokesperson for the Medical Staff in its external professional relations

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

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

9.6.2.2. serve as a voting member of the MEC

9.6.2.3. be automatically nominated for the Office of Chief of Staff at the next election

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

9.6.3.1. serve as a voting member of the MEC

9.6.3.2. advise the Chief of Staff and MEC on matters concerning the Medical Staff

9.6.3.3. perform other functions at the request of the Chief of Staff

9.6.3.4. assume the responsibilities, duties, and authority of the Chief of Staff when both the Chief and the Vice Chief of Staff are temporarily absent

9.6.4. Secretary-Treasurer. The responsibilities, duties, and authority of the Secretary-Treasurer are to:

9.6.4.1. serve as a voting member of the MEC

9.6.4.2. supervise any staff funds and perform other such duties as ordinarily pertain to the Office of Secretary- Treasurer

9.6.5. In the temporary absence of the Chief of Staff, Vice Chief of Staff, and the Immediate Past Chief of Staff, the Secretary-Treasurer shall assume all the duties and have the authority of the Chief of Staff.

9.6.6. Acting Chief of Staff. In the event that all four Officers are absent, the MEC shall appoint an acting Chief of Staff who shall assume all the duties and have the authority of the Chief of Staff.

ARTICLE 10

CLINICAL DEPARTMENTS

SECTION 1: ORGANIZATION

10.1.1. Structure. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who shall be responsible for the overall supervision of the clinical work within their Department and is selected and has the authority, duties, and specific responsibilities as specified in this Article.

10.1.2. Departments. There shall be Departments of Medicine, Surgery and OB/GYN and Pediatrics.

10.1.2.1. The Department of Medicine shall include any staff member in the following practice specialties: internal medicine, family practice, pulmonology/critical care, dermatology, oncology, hematology, nephrology, neurology, emergency medicine, radiology, gastroenterology, hematology/oncology, nuclear medicine, psychiatry, rheumatology, infectious disease, endocrinology, allergy / immunology, and the clinical section of cardiology.

10.1.2.2. The Department of Surgery shall include any staff member in the following practice specialties: general surgery, vascular surgery, neurosurgery, orthopedic surgery, plastic surgery, urologic surgery, ophthalmology, otorhinolaryngology, maxillofacial surgery, general dentistry and all dental specialties, podiatry, pathology, physiatry, and anesthesiology, pediatric surgery, colon/rectal surgery, cardio-thoracic .

10.1.2.3. The OB/GYN Department shall include any staff member in the following practice specialties: obstetricians and gynecologists

10.1.2.4. The Department of Pediatrics shall include any staff member in the following practice specialties: pediatrics, neonatology and pediatric cardiology.

10.1.3. Changes in Departments. Departments may be added, eliminated, divided or combined upon recommendation of the MEC with approval of the Governing Board.

10.1.4. Clinical Sections. When clinical sections are established, they shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which they function, and have a Chief of Section who is selected and has the authority, duties, and responsibilities as specified in this Article.

10.1.5. Formation of Clinical Sections. A group of practitioners of the same specialty who desire to become a clinical section must have a recommendation for such from the parent Department to the MEC. Denial of such a request by the Department must be accompanied by the reason for the denial. The MEC and Governing Board will then act on the request as follows:

10.1.5.1. If the MEC approves a positive recommendation from the Department, Committee recommendation is forwarded to the Governing Board.

10.1.5.2. If the MEC disagrees with a positive recommendation from the Department, the issue can then be referred to the next general Medical Staff meeting. The recommendation of the Medical Staff will then be forwarded to the Governing Board.

10.1.5.3. If a negative recommendation from the Department is supported by the MEC, the issue is considered closed.

10.1.5.4. If the MEC reverses a negative decision from the Department, the Department may request that the issue be referred to the next general Medical Staff meeting. The recommendation of the Medical Staff will then be forwarded to the Governing Board.

10.1.5.5. All final approval rests with the Governing Board.

10.1.6. Organization, Function and Responsibility of Clinical Section.

10.1.6.1. A section may elect a chief of the clinical section who may be of the Active, Courtesy or Associate staff when elected and must maintain Active, Courtesy or Associate staff privileges throughout the two (2) year term of office.

10.1.6.2. The section chief shall have the following duties and responsibilities:

10.1.6.2.1. recommend through the Department Chairperson and monitor core clinical privilege requirements and clinical privileges for section members

10.1.6.2.2. perform chart review and peer review functions of its members; such review will require the subsequent concurrence of the Department Chairperson

10.1.6.2.3. serve as Chairperson of the Department if eligible to fill that office according to these Bylaws

10.1.6.2.4. will in all cases be subject to the authority of the Department Chairperson

SECTION 2: RESPONSIBILITY OF DEPARTMENTS

10.2.1. Responsibility. The Departments shall:

10.2.1.1. 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

10.2.1.2. develop a procedure list (core privileges), and establish criteria for the granting of clinical privileges applicable to the Department and recommend same to the MEC

10.2.1.3. establish criteria for and implement mechanisms for focused review consistent with the Focused Professional Practice Evaluation Policy

10.2.1.4. monitor adherence to Bylaws, Rules and Regulations, and other Governance Documents

10.2.1.5. develop Department Rules and Regulations and policies, if called upon to do so

10.2.1.6. develop recommendations for continuing medical education, if called upon to do so

SECTION 3: ASSIGNMENT TO CLINICAL DEPARTMENTS

10.3.1. Assignment. Each member of the Medical Staff shall be assigned membership in one (1) Clinical Department, based on the bulk of the clinical services provided.

10.3.2. Meetings. Each member, if eligible, will be allowed to vote in only one Department and to represent only one Department or Committees (including the MEC).

10.3.3. Rules and Regulations. The exercise of clinical privileges granted by the Governing Board or the performance of specified services within any Department shall be subject to the Rules and Regulations of that Department and the defined authority of the Department Chairperson.

SECTION 4: FUNCTIONS OF CLINICAL DEPARTMENTS

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

10.4.1.1. objectively review, analyze, and evaluate the quality of care and performance provided though the Department. In the interest of achieving quality patient care and performance, each Department, through an established system, shall evaluate all clinical work performed under its jurisdiction, whether or not any particular practitioner or other individual with clinical privileges whose work is subject to such evaluation is a member of the Department. This must be done regularly and must be based on objective, measurable standards of care/performance. All or part of such review may be carried out through clinical services or designated specialty groups reporting the interpreted findings to the appropriate Medical Staff Department(s). Alternatively, a Department as a whole may perform the required review and evaluation functions. The Department may also elect to send the review to the MEC as outlined in these Bylaws

10.4.1.2. establish criteria for the granting of clinical privileges and, as appropriate, for the holding of office within the Department

10.4.1.3. recommend to the Credentials Committee the specific clinical privileges that each staff member or Medical Staff applicant may exercise in the Department and the specific services that each designated professional personnel may provide

10.4.1.4. establish such Committees or other mechanisms as are necessary and desirable to maintain quality clinical performance

10.4.1.5. monitor its members' performance on a concurrent basis for:

10.4.1.5.1. adherence to Medical Staff, Hospital, and Departmental Rules and Regulations, and policies/procedures

10.4.1.5.2. meeting requirements, alternate coverage arrangements, obtaining consultation when indicated, and adherence to sound principles of clinical practice

10.4.1.5.3. appropriate invasive procedures and other patient care interventions, clinical occurrences, including compliance with the Hospital Occurrence/Incident Screening Program (HOR)

10.4.1.5.4. all relevant aspects of patient safety.

10.4.1.6. fulfill the responsibilities designated to the Department as set forth in the quality/performance improvement plan

10.4.1.7. receive and evaluate the compliance with medical necessity (admission and intervention) and clinical management criteria, the findings from use of occurrence screening criteria, reports of Medical Staff and other Departmental Committees, and compliance with the established patient care requirements (rules, regulations, policies, protocols) of the Department and Medical Staff

10.4.1.8. coordinate with nursing and ancillary clinical patient care services, and with other administrative support services, the patient care provided by the Department's members

10.4.1.9. conduct or participate in, and make recommendations regarding the need for continuing education programs, pertinent to state-of-the-art changes, and, in particular, the findings of performance assessment and improvement activities

10.4.1.10. maintain a permanent record of all Department meetings/activities, if any, to include the discussion content as well as conclusions reached or actions taken or recommended. Copies of minutes will be transmitted to the MEC

SECTION 5: DEPARTMENT CHAIRPERSON AND VICE CHAIRPERSON

10.5.1. Qualifications. Each Chairperson and Vice Chairperson shall be a member of the Active Staff, qualified by training, experience, and demonstrated ability for the position. Each shall have demonstrated professional ability in at least one (1) of the clinical areas covered by the Department, shall meet all State regulatory requirements, and shall be willing, able, and eligible to discharge faithfully the functions of the office.

10.5.2. Selection of Chairperson and Vice Chairperson. Each Chairperson shall be elected by vote of the Active Department membership from nominees submitted to the Director of Medical Staff Services by Department members. The elected Chairperson shall appoint a Vice–Chairperson.

10.5.3. Terms of Office. Department Chairperson and Vice Chairperson shall serve a two (2) year term beginning on the first day of the Medical Staff term following their selection. The Department Chairperson may serve consecutive terms. The Department Chairperson shall serve until a successor is chosen, unless they shall resign sooner or be removed from office. In the temporary or permanent absence of the Department Chairperson, the Vice Chairperson shall assume all duties, responsibilities, and authority of the Chairperson, and will become a member of the MEC.

10.5.4. Removal of Department Chairperson or Vice Chairperson. Removal of a Department Chairperson or Vice Chairperson may be initiated by a two-thirds (2/3) majority vote of the Active Department members eligible to vote, and

subject to approval of the MEC. The MEC may remove for cause as outlined in these Bylaws, relating to removal of Medical Staff Officers.

10.5.5. Responsibilities, Duties, and Authority of Department Chairperson. Each Chairperson shall:

10.5.5.1. account to the MEC for all professional and administrative activities within their Department

10.5.5.2. consistent with Governance Documents, oversee the implementation of Peer Review activities in the Department

10.5.5.3. recommend to the MEC and Credentials Committee criteria for Clinical Privileges that are relevant to the services provided in the Department, consistent with determinations for same made in the Department

10.5.5.4. develop and implement, in cooperation with the Chief of Staff and consistent with these Bylaws, Rules and Regulations, Departmental mechanisms for performing the credentials review, delineating clinical privileges, and assigning staff classification; develop concurrent monitoring of practice/performance that is objective and measurable, including an occurrence screening program and the use of medical necessity and clinical management criteria; review quality management activities; support continuing medical education; review utilization; oversee the implementation of the FPPE and OPPE policies for the Department

10.5.5.5. transmit to the Credentials Committee the Department's recommendation concerning appointment and reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in the Department

10.5.5.6. maintain ongoing review of the professional performance of all practitioners and any Allied Health Professionals within the Department, contribute data to individual practitioner's performance profiles, and report regularly to the Credentials Committee and MEC upon request and at the time of reappointment, including evidence of consideration of each practitioner's health status in terms of the practitioners ability to practice in the area in which privileges are exercised

10.5.5.7. develop, implement, and enforce, in cooperation with the Chief of Staff and/or Vice Chief of Staff, programs to perform the quality assessment and improvement and maintenance functions delegated to the service

10.5.5.8. serve as a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding their own Department in order to promote quality patient care. Within each Department, the Chairperson shall implement actions taken by the MEC

10.5.5.9. enforce the Hospital and Medical Staff Bylaws, Rules and Regulations, and the Departmental Rules and Regulations, if any, including, when appropriate, the initiation of corrective action and investigative services and participate as a consultant on an as-needed basis when their department is involved

10.5.5.10. actively encourage all Department members to complete adequately the medical records of their discharged patients within the period required by these Bylaws, Rules and Regulations, and by any regulatory agency

10.5.5.11. verify that Focused Professional Practice Evaluations are completed and evaluate results for staff members who are in provisional status as newly appointed staff members or as otherwise required by MEC

10.5.5.12. participate in the ongoing assessment and improvement of the services, treatments, and quality of care provided in the Department

10.5.5.13. cause Department Rules and Regulations relating to standards of patient care to be developed, approved, implemented, and reviewed periodically for any needed revision

10.5.5.14. aid in the development and implement policies and procedures that guide and support the provision of care, treatment, and services, as needed

10.5.5.15. aid in the determination of qualifications of and make recommendations for Allied Health Professionals seeking to provide or perform specified services in the Department

10.5.5.16. recommend space and other resources needed by the Department or service

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

10.5.5.18. cause all standing orders of practitioners to be reviewed initially, upon any 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)

10.5.5.19. assess and recommend to the MEC off-site sources for needed patient care services not provided by the Department/Service or the Hospital

10.5.5.20. determine who, outside of the department members, the Chief of Staff, CEO or their designee, Quality Management Coordinator, and Recording Secretary, may attend Department meetings

10.5.5.21. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the MEC, or Governing Board

10.5.5.22. coordinate and integrate interdepartmental and intradepartmental services as needed

10.5.5.23. act as Presiding Officer at all Department meetings and cause a permanent meeting report to be maintained and distributed as required

10.5.6. Duties of Vice Chairperson. The Vice Chairperson shall assist in performance of the Chairperson's duties and assume their position if the Chairperson is not available.

ARTICLE 11

COMMITTEES & FUNCTIONS

SECTION 1: GENERAL CONSIDERATIONS

11.1.1. Standing and Special Committees. There shall be standing and special (Ad Hoc) Committees of the Medical Staff. Unless stated otherwise in these Bylaws or Rules and Regulations, the Committees of this Article shall be standing Committees of the Medical Staff. Special or Ad Hoc Committees may be created by the MEC to perform specified tasks.

11.1.2. Appointment and Removal. Unless otherwise specified, the Chairperson and members (except the MEC and its Chairperson) of all Committees shall be appointed by the Chief of Staff for a two (2) year term and may be removed by the Chief of Staff after consultation with and approval of the MEC. A physician may succeed themselves as Chairperson of a Committee.

11.1.3. Minutes. Unless stated otherwise in these Bylaws or Rules and Regulations, each Committee shall submit a copy of its minutes to the MEC and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions.

11.1.4. Participation of Non-Medical Staff Members. Persons who participate in or attend Committees or functions who are not Medical Staff members shall be selected by the CEO with the concurrence of the Committee Chairperson or Chief of Staff. Non-Medical Staff members shall not be entitled to vote, but may participate in discussion.

11.1.5. Ex officio members. Ex officio Committee members shall serve without vote.

11.1.6. Performance of Functions.

11.1.6.1. Whenever these Bylaws or Rules and Regulations require that a function be performed by a Medical Staff Committee but no

Committee has been specified, the MEC shall perform the function or designate a Subcommittee to perform that function.

11.1.6.2. Whenever these Bylaws or Rules and Regulations require that a function be performed by the MEC, but a standing or special Committee has been formed to perform the function, the Committee so formed shall act in accordance with the authority delegated to it.

11.1.7. Vacancies. Unless stated otherwise in these Bylaws or Rules and Regulations, vacancies on any Committee shall be filled in the manner of original appointment to the Committee. If an individual obtains membership by virtue of these Bylaws and is removed for cause, a successor may be selected by the Chief of Staff.

SECTION 2: MEDICAL EXECUTIVE COMMITTEE.

11.2.1. Role. The role of the MEC is to carry out responsibilities of the 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.

11.2.2. Composition. The MEC shall be a standing Committee of the Medical Staff of which the voting members are fully licensed doctors of medicine or osteopathy. Membership on the Committee shall be comprised of eighty percent (80%) Active, and no more than three (3) non-Active Medical Staff members. It shall consist of the Officers of the Staff: Chief of Staff, Vice-Chief of Staff, and Secretary-treasurer; Chairpersons of all Medical Staff Departments; the most recent ex-Chief of Staff, the Chairperson of the Credentials Committee; the Chairperson of the Acute Care Services Committee; the Chairperson of the PI Committee; the Chairperson of the Peer Review Committee; the Chairperson of the Bylaws Committee; and two (2) or more members selected at large from the Medical Staff by the Chief of Staff. The Chief Medical Officer or physician Advisor of the Hospital shall be an ex-officio member without vote, and the CEO of the Hospital shall be an ex-officio member without vote. The Chief of Staff shall be Chairperson of the Committee. Each voting member, regardless of staff, Department, or other Committee position held, shall have only one vote. The Chief of Staff shall vote only in the event of a tie vote.

11.2.3. Responsibilities, Duties, and Authority. The primary responsibilities of the MEC are to:

11.2.3.1. act on the behalf of the Medical Staff between meetings of the organized Medical Staff

11.2.3.2. make recommendations to the Governing Board on all matters relating to appointments, reappointments, clinical privileges, staff category and Clinical Department/Section assignments, and corrective action. When Allied Health Professionals provide or are recommended to provide services in the Hospital, the Committee shall make recommendations to the Governing Board regarding their qualifications to provide those services and on the degree of supervision required

11.2.3.3. receive and act upon reports and recommendations from Medical Staff Committees, all Clinical Departments, and Staff Officers concerning performance improvement activities and the discharge of their delegated administrative responsibilities

11.2.3.4. ensure that each Medical Staff peer evaluation and performance assessment and improvement activity is performed effectively

11.2.3.5. coordinate the activities of, and policies adopted by, the staff, Departments/Sections, and Committees

11.2.3.6. enforce Medical Staff Bylaws, Rules and Regulations and appropriate Hospital rules and policies; implement sanctions when they are indicated

11.2.3.7. enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a practitioner

11.2.3.8. be accountable to the Governing Board for the quality of professional services rendered, including the organization and implementation of performance improvement activities to improve quality of care, treatment, and services and patient safety

11.2.3.9. set, maintain and enforce standards for professional performance in the Hospital consistent with generally recognized standards for patient care and safety

11.2.3.10. 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

11.2.3.11. request evaluations in instances where there is doubt about a Practitioner's ability to perform privileges requested

11.2.3.12. review and make recommendations to the Governing Board relating to the structure of the Medical Staff and the process used to review credentials and delineate privileges

11.2.3.13. appoint Ad Hoc Committees to review and make recommendations to the MEC on specific matters

11.2.3.14. receive and act on Hospital reports, including reports related to utilization management, infection control, and case management

11.2.3.15. assist in obtaining and maintaining accreditation

11.2.3.16. review and act on matters relating to finances of the Medical Staff

11.2.3.17. keep the Medical Staff as a whole informed of its activities and pertinent developments

11.2.3.18. have the authority to adopt Medical Staff policies in accordance with these Bylaws, and to adopt such procedures and implement details as may be reasonably necessary to carry out duly promulgated Rules and Regulations and Medical Staff policies effectively

11.2.3.19. provide oversight in the process of analyzing and improving patient satisfaction

11.2.3.20. monitor the quality of medical histories and physical examinations

11.2.3.21. initiate and pursue corrective action, when warranted, in accordance with the Medical Staff Bylaws, Rules and Regulations and policies

11.2.3.22. take all reasonable steps to help provide for professional ethical conduct and clinical performance on the part of all staff members

11.2.3.23. make recommendations to the Governing Board on medico-administrative and Hospital management matters as requested, particularly as they relate to patient care, through the CEO and Chief of Staff

11.2.3.24. review and approve all Hospital policies and procedures pertaining to the Medical Staff

11.2.3.25. submit recommendations to the Governing Board for changes in the Medical Staff Bylaws, Rules and Regulations and other organizational documents pertaining to the Medical Staff

11.2.3.26. serve as a liaison to provide and promote effective relationships among the Medical Staff, Administration, and the Governing Board

11.2.3.27. participate in identifying community health needs, setting Hospital goals, and implementing programs to meet those needs and goals

11.2.3.28. actively maintain effective Medical Staff participation in the Hospital's occurrence screening program

11.2.3.29. promote in-house Medical Staff continuing education activities that are relevant to the care and services provided in the Hospital and, in particular, to the findings of Medical Staff peer evaluation and performance improvement activities

11.2.3.30. be actively involved in pain assessment, pain management, and safe opioid prescribing by participating in establishment of protocols and quality metrics and review of performance improvement data

11.2.4. Removal of MEC Members. Except for removal of Officers, which shall be handled in accordance with the provisions for removal of Officers (Article 9, Section 5), 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.

11.2.5. Resolution of Conflict. In the event of conflict between the MEC and members of the Medical Staff on matters of governance, the Chief of Staff shall convene a meeting of senior 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.

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

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

11.2.6. Meetings. It is expected that the MEC shall meet monthly and as often as necessary to accomplish its function.

SECTION 3: CREDENTIALS COMMITTEE

11.3.1. Composition. The Credentials Committee shall be a standing Committee of the Medical Staff and shall consist of five (5) or more members of the Medical Staff. The CEO or designee shall serve as a member of the Committee ex officio but shall not vote. A member of the Governing Board may also serve as an ex officio member of the Committee, without vote. The physician members shall include the Chairpersons of Clinical Departments. The Chairperson of the Committee shall be an Active member of the Medical Staff appointed by the Chief of Staff.

11.3.2. Role of Credentials Committee. The role of the Committee shall be to review the credentials of applicants for appointment and reappointment to the Medical Staff and to make recommendations to the MEC regarding Medical Staff membership and delineation of Privileges for individual applicants. The Committee shall review and approve new or revised credentials and Privileges, forms and procedures. The Committee shall also review and act upon recommendation of appointment of AHPs for permission to perform specified services. The Committee shall interview members or applicants, and the Department Chief as necessary, for matters relating to appointment and reappointment or change in privileges.

11.3.3. Responsibilities of the Committee include:

11.3.3.1. making a recommendation of appointment or reappointment, after considering evidence of:

11.3.3.1.1. challenges to licensure or registration

11.3.3.1.2. voluntary and involuntary relinquishment of any license or registration

11.3.3.1.3. voluntary and involuntary termination of Medical Staff membership

11.3.3.1.4. voluntary and involuntary limitation, reduction or loss of clinical privileges

11.3.3.1.5. evidence of an unusual pattern or excessive number of professional liability actions

11.3.3.1.6. the applicant's health status, morbidity and mortality data when available, relevant Practitioner specific data as compared to aggregate data when available

11.3.3.1.7. entry into a Board Action with any licensing Board whether public, non-public, private or non-disciplinary

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

11.3.3.1.9. considering whether there is sufficient clinical performance information to make a recommendation

11.3.3.1.10. 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

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

11.3.3.2. Meetings: It is expected that the Credentials Committee shall meet monthly and as often as necessary to accomplish its function.

SECTION 4: ENVIRONMENT OF CARE

11.4.1. Composition. The Environment of Care Committee shall be a standing Committee of the Medical Staff and shall consist of at least one physician member from the Medical Staff appointed by the Chief of Staff who will serve as Chairperson, the CEO or designee, the Chief Nursing Officer or designee, the Quality Improvement Coordinator, the Risk Manager, a representative from employee health and other Hospital Staff as appointed by the CEO. Other individuals from either the Medical or Hospital Staffs may participate as consultants on an as-needed basis.

11.4.2. Responsibilities, Duties, and Authority. The Committee shall:

11.4.2.1. review quality control reports from the various Hospital Departments to identify any trends and/or opportunities for improvement

11.4.2.2. receive, analyze, and recommend action regarding any significant findings from quality control, safety or infection control reviews

11.4.2.3. receive and review safety reports including those related to emergency preparedness, provide input to effect positive change, review and approve safety policies

11.4.2.4. perform at least an annual evaluation of the Environment of Care program to assure its comprehensiveness and effectiveness

11.4.2.5. assure that an updated report is presented to the MEC and Governing Board annually

11.4.2.6. receive reports and monitor a preventive and corrective program designed to improve employee health program

11.4.2.7. institute appropriate control measures or studies if there is suspicion of a danger to patients or personnel. When the situation is considered to be urgent, the Committee Chairperson or a physician member of the Committee may institute the control measure immediately and will be assisted by Hospital personnel in doing so. The Chief of Staff and the CEO shall be notified as soon as any urgent control measure is instituted and shall be consulted prior to the institution of any non-urgent measure. The attending practitioner shall be notified as soon as possible; however, when the patient's attending practitioner does not consider the measure necessary (e.g., the need to isolate a patient), the decision of the Committee Chairperson or infection control practitioner in following established infection control policy, shall prevail

11.4.2.8. receive reports from the Code Blue Committee, which functions as a Subcommittee of the Environment of Care Committee.

11.4.3. Meetings. The Environment of Care Committee shall meet as often as necessary to accomplish its functions, but at least (6) six times per year. The overall findings will be sent to the MEC.

SECTION 5: PHARMACY AND THERAPEUTICS COMMITTEE

11.5.1. Composition. The Pharmacy and Therapeutics (P&T) Committee is a standing Committee of the Medical Staff and shall consist of at least one physician appointed by the Chief of Staff, who shall serve as the Chairperson of the Committee. The other members of the P & T Committee shall include pharmacy service, a representative from the Laboratory, Infection Control, Administration and from Nursing Services and when indicated, a Clinical Dietician.

11.5.2. Responsibilities, Duties & and Authority. The Committee shall:

11.5.2.1. evaluate the clinical usage of drugs (particularly high risk, problem-prone and investigative drugs) in the Hospital, establishing priorities for specific drug or drug category reviews using measurable criteria in the review process. After any required peer review, the findings will be entered into the appropriate practitioner performance profiles

11.5.2.2. establish and implement a well controlled or closed formulary to help control the use of drugs in the Hospital. The Committee will make recommendations to the MEC regarding any changes to the formulary. Requests for formulary changes from individual Medical Staff members must be submitted to the P&T Committee in writing and include the rationale for the change. The Committee Chairperson will transmit the Committee's decision to the requesting practitioner

11.5.2.3. define and evaluate all significant untoward reactions to drugs

11.5.2.4. strive for adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic in-service training for nursing personnel and other appropriate Hospital personnel

11.5.2.5. define and evaluate all significant medication errors

11.5.2.6. evaluate initially, when changes are made, and at least annually, standing and routine orders containing medication orders

11.5.2.7. assist in the formulation of and approval of all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drug usage in the Hospital

11.5.2.8. ensure the adequacy and centralization of intravenous mixtures, total parenteral nutrition, and the mixture of chemotherapeutic agents

11.5.2.9. make recommendations to the MEC on protocols proposed for the use of investigational or experimental and high-risk drugs and specific drug categories for use in the Hospital

11.5.2.10. review statistics and reports related to blood and blood product ordering, handling, dispensing, administering, and monitoring the effects on patients and make recommendations as needed

11.5.2.11. maintain an objective ongoing evaluation of the clinical use of all antibiotics used in the Hospital, whether the drugs are prescribed prophylactically, empirically, or therapeutically. The Committee shall recommend action for any required practice change to the MEC and shall follow-up through the Performance Improvement Committee to be sure the approved change has occurred. The Committee shall recommend objective and measurable criteria for use in all facets of antibiotic use evaluation

11.5.2.12. evaluate clinical practice objectively for compliance with measurable criteria for the use of whole blood and each of its components administered in the Hospital

11.5.2.13. evaluate untoward transfusion reactions and report such transfusion reactions, including the recommendation of periodic in-service training for nursing personnel to identify such reactions

11.5.2.14. maintain and evaluate blood use statistics in order to determine blood waste and recommend or take appropriate action

11.5.2.15. encourage the increased use of the type-and-screen vs. type-and-crossmatch procedure, based on periodic (e.g., annual) actual use statistics by practitioner, Departments/Clinical Specialties, and specific therapeutic interventions (e.g., specific surgical procedures, etc.)

11.5.2.16. review blood and blood product usage. Any isolated instances or patterns of inappropriate blood usage felt to be significant in the view of the Committee will be referred to the appropriate Department for further review

11.5.2.17. set priorities for any aspect of blood therapy evaluation

11.5.3. Meetings. The Pharmacy and Therapeutics Committee shall meet as often as necessary to accomplish its function, but at least four (4) times per year.

SECTION 6: OPERATING ROOM ("OR") COMMITTEE

11.6.1. Composition. The Operating Room Committee shall be a standing Committee of the Medical Staff and shall consist of members of the Medical Staff appointed by the Chief of Staff and shall include the Director of Anesthesia Services. The Chairperson shall be the Chairperson of the Department of Surgery or their designee. In addition, the Committee shall have representation from the Administration, Director of Surgical Services, and other support areas as needed.

11.6.2. Responsibilities, Duties, and Authority. The responsibilities of the Operating Room (OR) Committee shall be to:

11.6.2.1. review and monitor utilization of the operating room time, including starting times, operative times, and efficient daily running of the operating room schedule

11.6.2.2. develop policies concerning hours of the operating room operation, including times that elective cases may be scheduled, as well as hours during the week that will be designated as emergency operative time

11.6.2.3. develop policies concerning the posting and scheduling of patients and efficient utilization of all available time and space in the operating room. Develop policies and procedures as deemed necessary from

time to time to assure the most cooperative and efficient use of the operating room

11.6.2.4. review performance improvement procedures

11.6.2.5. make recommendations to ECMC for obtaining new OR equipment, and review of OR design change

11.6.2.6. assume other duties and responsibilities as would naturally fall under the direction of an OR Committee

11.6.3. Meetings. The OR Committee shall meet at least quarterly or as often as necessary to accomplish its functions.

SECTION 7: PERFORMANCE IMPROVEMENT COMMITTEE

11.7.1. Composition. The Performance Improvement Committee is a standing Committtee of the Medical staff and shall consist of at least one physician of the Medical Staff appointed by the Chief of Staff who shall serve as the Committee Chairperson and who will be a standing member of the MEC. The other members of the PI Committee shall include the CNO, COO, Quality Management Coordinator, and Department Directors as needed.

11.7.2. Responsibilities, Duties, Authority. The Committee shall be responsible for performance improvement through:

11.7.2.1. providing oversight to the implementation of the Hospital's plan for performance improvement

11.7.2.2. reviewing and approving Department performance improvement indicators, data to be collected and interventions

11.7.2.3. recommending and/or approving performance improvement teams for the purpose of process improvement

11.7.2.4. review and evaluation of, and approving, performance improvement data analysis and intervention

11.7.2.5. providing to the MEC and the Governing Board an annual evaluation of the effectiveness of all aspects and components of the performance improvement process and recommendation for improvement and a projected plan for the following year

11.7.3. Meetings. The Performance Improvement Committee shall meet as often as needed.

SECTION 8: BYLAWS, RULES AND REGULATIONS COMMITTEE

11.8.1. Composition. The Bylaws, Rules and Regulations Committee is a standing Committee of the Medical Staff and shall consist of three (3) or more physician

members of the Medical Staff appointed by the Chief of Staff. The Chairperson of the Committee shall be an Active Staff member appointed by the Chief of Staff and shall serve as a standing member of the Medical Executive Committee.

11.8.2. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the Bylaws, Rules and Regulations Committee shall be to:

11.8.2.1. review the Medical Staff Bylaws, Rules and Regulations on an ongoing and periodic basis and to recommend to the MEC and the Governing Board any changes deemed necessary for compliance with applicable laws and accreditation requirements

11.8.2.2. ensure, through ongoing review, that the Bylaws, Rules and Regulations reflect current practice and an efficient organization of the Medical Staff in performing its functions

11.8.2.3. when requested to do so by the MEC, ask each Clinical Department to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, Rules and Regulations and with Hospital and Governing Board policies

11.8.3. Meetings. The Bylaws, Rules and Regulations Committee shall meet as often as necessary to accomplish its functions.

SECTION 9: MEDICAL RECORD/UTILIZATION REVIEW COMMITTEE

11.9.1. Composition. The Medical Record/Utilization Review Committee is a standing Committee of the Medical Staff and shall be chaired by a member of the Medical Staff appointed by the Chief of Staff. The Committee shall include representatives from Administration and Nursing Services, the Utilization Review Coordinator and Discharge Planner, and the Health Information Services Director.

11.9.2. Responsibilities, Duties, and Authority. The Committee shall:

11.9.2.1. review and evaluate medical records objectively, using prescribed work sheets, to assist in providing records that are adequate with regard to:

11.9.2.1.1. continuity of care

11.9.2.1.2. use in quality assessment and improvement activities

11.9.2.1.3. assisting in protecting the legal interest of the patient, the Hospital, and the responsible practitioner

11.9.2.1.4. clinical pertinence (particularly all significant changes in patient status)

11.9.2.1.5. required documentation

11.9.2.1.6. patient/family involvement in the plan of care

11.9.2.1.7. receipt and acknowledgment of patient/family instructions

11.9.2.1.8. age specific information (particularly for infants and children)

11.9.2.1.9. pertinent psychosocial information

11.9.2.1.10. evidence of informed consent

11.9.2.2. establish the format of the medical record in concert with the director of the Health Information Management Department, and review and advise the CEO and MEC regarding all forms to be used in the medical record

11.9.2.3. review and recommend approval, when appropriate, of all policies, rules, and regulations relating to medical records

11.9.2.4. develop, or cause to be developed and implemented a record review system that, over a reasonable period of time, causes a representative sampling of the records of all practitioners to be evaluated for quality and clinical pertinence

11.9.2.5. furnish to Medical Staff and Administration on a regular basis timely statistical data, the nature of which is to be determined through the information needs of the Hospital and Medical Staff

11.9.2.6. comply with applicable requirements of the utilization review plan approved by the Medical Staff and Governing Board

11.9.2.7. require documentation that utilization review is applied regardless of payment source

11.9.2.8. require that focused reviews be emphasized

11.9.2.9. determine whether under utilization and/or over utilization of practices has an adverse impact upon the quality of patient care and recommend appropriate corrective actions to be taken

11.9.3. Meetings. The Medical Record/UR Committee shall meet as often as necessary to accomplish its functions and clinical pertinence review.

SECTION 10: MEDICAL ETHICS COMMITTEE

11.10.1. Composition. The Medical Ethics Committee shall be a standing Medical Staff Committee that shall have Medical Staff members and a Chairperson appointed by the Chief of Staff. It may include lay representatives, nurses, social workers, clergy, ethicists, and an attorney and the CEO (or designee).

11.10.2. Responsibilities. The mission of the Committee is to review ethical considerations relating to patients, the Hospital or Medical Staff and the Medical Ethics

Committee's completed case review will be presented to the MEC. The Medical Ethics Committee members may not participate in the initial or continuing case review in which the member has a conflicting interest except to provide information as requested by the Committee. The Committee may, at its discretion, invite nonvoting individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the Committee.

11.10.3. Meetings. The Medical Ethics Committee shall meet as often as necessary to accomplish its functions at the call of the Chairperson. The Committee shall review cases at convened meetings at which a majority of the members of the Committee are present. The Committee shall prepare and maintain adequate documentation of Medical Ethics Committee activities and shall report to the MEC.

SECTION 11: ACUTE CARE SERVICES COMMITTEE

11.11.1. Composition: The Acute Care Services Committees shall be a standing Committee of the Medical Staff, and shall consist of Active Medical Staff members appointed by the Chief of Staff and shall include one Intensivist. The Chairperson of the Acute Care Committee shall be appointed by the Chief of Staff and eligible appointees as Chairperson shall include the intensivist member. The Chairperson of the Acute Care Committee shall be a member of the MEC. The Acute Care Committee membership will include the Director of Acute Care Service and the service line specific nurse managers. Other appropriate personnel will be appointed as deemed necessary by the Chairperson of the Committee or the CEO.

11.11.2. Responsibilities, Duties, and Authority. The Committee shall be responsible for:

11.11.2.1. enhancing the quality of care on the Acute Care Units [Medical/Surgical, Progressive Care and Critical Care]

11.11.2.2. assisting Administration in planning programs of care for the continued growth of the Acute Care Units

11.11.2.3. making recommendations for patient flow and interacting with the other Clinical Departments in matters that affect the operations of the Acute Care Units

11.11.2.4. identifying the patient care needs and promoting the attainment of patient care goals

11.11.2.5. serving as a liaison between the Nursing Staff, Medical Staff, and Administration

11.11.2.6. making recommendations to the Medical Executive Committee on any area of quality control issues or recommendations for the improvement in Hospital services

11.11.3. Meetings. It is expected that the Acute Care Services Committee and Critical Care Committee shall meet quarterly and as often as necessary to accomplish its function.

SECTION 12: PATIENT SAFETY COMMITTEE

11.12.1. Composition: The Patient Safety Committee shall be a standing Committee of the Medical Staff and shall consist of the Chief of Staff or their designee, who shall serve as Chairperson, other Medical Staff, members as designated by the Chief of Staff, and the Patient Safety Officer. The Committee shall call upon other physicians and Hospital Staff members to participate in Committee meetings as necessary.

11.12.2. Responsibilities, Duties, and Authority. The Committee shall be responsible for:

11.12.2.1. providing a systematic, coordinated and continuous approach to maintenance and improvement of patient safety

11.12.2.2. developing a confidential system to track near misses, adverse events, sentinel events for patients, physicians and staff

11.12.2.3. assembling relevant patient safety data from internal and external sources

11.12.2.4. presenting Patient Safety findings and actions to the MEC

11.12.2.5. conducting proactive risk assessment of a high-risk process identified in the Joint Commission Sentinel Event Alert or as identified by the Committee

11.12.2.6. monitoring and tracking Occurrence reports

11.12.2.7. surveying patients, family members , Medical Staff and other staff regarding their opinions, needs and perceptions of the risks to patients

11.12.2.8. ensuring that unanticipated outcomes are communicated to patients or families and that appropriate clinical measures are taken to respond to the unanticipated outcome.

11.12.3. Meetings. The Patient Safety Committee shall meet quarterly or as often as necessary to accomplish its function.

SECTION 13: PEER REVIEW COMMITTEE

11.13.1. Composition. The Peer Review Committee is a standing Committee of the Medical Staff and shall consist of a Chairperson who is an Active member of the Medical Staff and other physician members appointed by the Chief of Staff. The Chief Medical Officer or Physician Advisor will serve as an ex-officio adviser and non-voting member of the Committee.

11.13.2. Responsibilities, Duties, and Authority. The Committee shall:

11.13.2.1. conduct fair, meaningful, and comprehensive peer review by assessing data measuring physician performance with respect to the following:

11.13.2.1.1. medical assessment and treatment of patients

11.13.2.1.2. medication use and management

11.13.2.1.3. operative and other invasive procedures

11.13.2.1.4. resuscitation and its outcomes

11.13.2.1.5. the appropriateness of clinical practice patterns

11.13.2.1.6. assess aspects of physician behavior as it relates to appropriate medical management of patients and is intended to be 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. The Committee shall provide a mechanism to maintain the confidentiality of individuals seeking referral or referred for assistance

11.13.2.1.7. assess departures from the usual utilization practices

11.13.2.1.8. utilize FPPE/OPPE as appropriate

11.13.3. Processes. The Committee shall:

11.13.3.1. conduct individual case reviews where performance is questioned as a result of measurement and assessment activities or as required by the MEC. An initial screening review will be done by either the Clinical Department or the Chief Medical Officer. The body doing the initial screening review will be determined by the individual Clinical Department. The Clinical Department may consult a specialty reviewer who either inside or outside the Hospital's Medical Staff if needed to conduct individual case reviews. Charts reviewed by the Chief Medical Officer that need

further review will be referred to the appropriate Clinical Department. Charts deemed by the Clinical Department to need still further review will be referred to the MEC. The Chief Medical Officer may do an independent screening review on any charts initially screened by a Clinical Department. Alternatively, the MEC may direct that a review be performed as a result of a complaint or request for such review by Medical or Hospital Staff, or patients

11.13.3.2. provide for participation in the review process by the individual whose performances are being reviewed

11.13.3.3. collect and maintain individual practitioner data for tracking trends to enhance education, patient safety, and quality improvement

11.13.3.4. report composite data to the Clinical Departments, MEC, and Governing Board as indicated

11.13.3.5. provide individual practitioner data to the Credentials Committee for use in the reappointment process

11.13.3.6. refer appropriate cases to the Clinical Department, MEC, Governing Board or other entities to consider any recommended disciplinary action

11.13.4. Meetings. The Peer Review Committee shall meet as often as necessary to accomplish its function.

SECTION 14: INFECTION PREVENTION COMMITTEE (IPC)

11.14.1. Composition. The Infection Prevention Committee shall be a standing Committee of the Medical Staff and shall consist of members and a Chairperson that are appointed by the Chief of Staff. The IPC and its designated representatives, including the Medical Director of Infection Prevention and the Infection Preventionist, as well as representatives from the following: Nursing Leadership, Nursing Departments, Lab, Pharmacy, Cardiopulmonary, Safety, Risk Management, and Quality. Other Department Representatives may be adjunct members as needed.

11.14.2. Responsibilities, Duties and Authority. The Committee shall:

11.14.2.1. bring clinical, administrative or epidemiologic expertise to the Committee

11.14.2.2. participate in the data evaluation

11.14.2.3. review and approve infection prevention and control policies and procedures

11.14.2.4. review designated microbiological reports

11.14.2.5. review patient infections (healthcare acquired versus community-acquired). The review consists of the following:

11.14.2.5.1. methods of possible prevention or intervention to reduce the risk of further exposure

11.14.2.5.2. surveillance data prevalence and incidence studies routine or special collection of other data

11.14.2.5.3. approve any sampling of personnel or the environment for infective agents. This sampling is appropriate when:

11.14.2.5.3.1. the professional judgment of the Committee or its designee deems it appropriate

11.14.2.5.3.2. an epidemic or when clusters of infections occur

11.14.2.5.3.3. required by Local, State or Federal law or regulation

11.14.2.5.3.4. needed as a quality control mechanism

11.14.2.5.3.5. needed as an educational or training exercise

11.14.2.6. evaluate, revise as necessary, and approve the type and scope of surveillance activities. This is accomplished by reviewing:

11.14.2.6.1. data trend analysis generated by surveillance activities during the year

11.14.2.6.2. the risk effectiveness of prevention and control intervention strategies in reducing the nosocomial infection risks

11.14.2.6.3. services instituted and procedures, priorities or problems identified in the last year

11.14.2.7. approve actions to prevent and control infections

11.14.2.8. provide that conclusions, recommendations and actions (including responsibility of initiation) are documented in Committee meeting minutes and are reported to the MEC

11.14.2.9. authorize the Infection Preventionist to institute any surveillance, prevention or control measure as approved by Hospital Administration and Medical Staff

11.14.2.10. determine the amount of time needed in infection surveillance, prevention and control activities

11.14.3. Meetings. The IPC shall meet as often as needed to accomplish its functions, but at least four (4) times a year.

SECTION 15: HUMAN RESEARCH ADVISORY COMMITTEE

11.15.1. Composition. The Human Research Advisory Committee shall be composed of the Medical Ethics Committee Chairperson, who will sit as a member of the Facility Review Committee (FRC). The FRC is a multi-disciplinary Hospital Committee, organized as needed, designed to review proposed medical research prior to full evaluation by a contracted Institutional Review Board (C-IRB).

11.15.2. Responsibilities. The Chairperson of the Human Research Advisory Committee, or designee, will report proposed medical research, already approved by the FRC and the C-IRB, to the MEC for its consideration and recommendation. Any MEC objection to the proposed research shall be transmitted to the CEO and the FRC for reconsideration of any approvals given.

11.15.3. Meetings. In lieu of meetings, the Medical Ethics Committee Chairperson shall forward a report to the MEC, as necessary.

ARTICLE 12

MEETINGS

SECTION 1: QUARTERLY MEDICAL STAFF MEETINGS

12.1.1. Regular Meeting. Medical Staff meetings shall be held on a quarterly basis. The agenda shall include cumulative reports by Staff Officers and by Committee and Department Chairperson for the review and evaluation of the work done. Elections for staff office will be held at this meeting as provided in these Bylaws. The Chief of Staff shall preside at all general meetings of the Medical Staff.

12.1.2. Order of Business and Agenda. The order of business and agenda of the Quarterly Medical Staff meeting will be determined by the Chief of Staff.

12.1.3. Special Meeting. Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the written request of the CEO, Governing Board, the MEC, or by a request signed by at least 25% of the Active staff members. The Chief of Staff shall call a special meeting within seven (7) days of this written request.

12.1.3.1. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail or electronic means, to each member of the Active staff not less than five (5) nor more than ten (10) days before the date of such meeting, by or at the direction of the Chief of Staff. Notice may also be sent to members of other Medical Staff groups who have so requested. If a Medical Staff member is present at the time a specific meeting is called, this shall constitute a waiver of notice of such meeting.

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

12.1.3.3. All quorum requirements will apply.

SECTION 2: COMMITTEE AND DEPARTMENT MEETINGS

12.2.1. Medical Staff Committees, Department, and Clinical Sections may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. Committees shall meet as required by these Bylaws, Rules and Regulations.

12.2.2. Special Meeting. A special meeting of any Committee or Department may be called by or at the request of the Chairperson or Chief thereof, by the Chief of Staff, or by 25% of the group's current voting members. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.2.3. Notice of Meetings (Committee or Department).

12.2.3.1. Notice of regular meetings may be given orally or in writing or by electronic means.

12.2.3.2. For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day and hour of the meeting shall be given to each member not less than five (5) days before the time of such meeting.

12.2.3.3. The attendance of the Medical Staff member at the time a specific meeting is called, constitutes a waiver of notice to such meeting.

SECTION 3: QUORUM

12.3.1. Quarterly Staff Meeting (Regular or Special).

12.3.1.1. The presence of ten percent (10%) of the voting members of the Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of transaction of any business including amendment to the Bylaws, Rules, and Regulations and the election of Staff Officers. A simple majority of those voting members who cast votes will be required to make decisions for the Medical Staff.

12.3.1.2. In the event that a quorum is not present at any regular or special meeting, a request for vote will be forwarded to all Active members by electronic means. Those members present may meet as a Sub-Committee of the whole. Any action taken by those present, acting as a Sub-Committee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

12.3.2. Medical Executive Committee.

12.3.2.1. One-half (1/2) of the voting members of the MEC shall constitute a quorum for the purpose of transaction of business.

12.3.2.2. In the event that a quorum is not present at any regular or special meeting, a request for vote will be forwarded to all voting members by electronic means. Those members present may meet as a Sub-Committee of the whole. Any action taken by those present, acting as a Sub-Committee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

12.3.2.3. As necessary, the Chief of Staff may be counted in obtaining a quorum at any regular or special meeting.

12.3.3. Department Meeting. Three (3) members in addition to the Chairperson of the Department shall constitute a quorum in any meeting.

SECTION 4: MANNER OF ACTION

12.4.1. Except as otherwise specified in these Bylaws, the action of the majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.

12.4.2. Action may be taken without a meeting of a Committee or Department with the approval of the Committee or Departmental Chairperson, if such proposed action is submitted in writing or by electronic means, setting forth the action so taken. Such action shall be signed by hand or by electronic means and dated, by a majority entitled to vote.

SECTION 5: MEETING MINUTES

12.5. Minutes of all meetings shall be prepared by the coordinator of the meeting and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief summary of all issues discussed, indicating any recommendation made and forwarded, conclusions reached, and actions taken. The minutes shall be signed by the Presiding Officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting (and actions taken without an actual meeting) shall be maintained.

SECTION 6: ATTENDANCE REQUIREMENT

12.6.1. Attendance. Attendance at Departmental meetings is determined by each Department. Attendance at Departmental meetings is required for a member of the Medical Staff when one of the member's cases is being reviewed or when the member is assigned to review cases of their peers.

12.6.2. Absence from Meeting. A member who is compelled to be absent at required Departmental meetings shall provide promptly in writing or verbally to the Medical Staff Services Director the reason for such absence.

12.6.3. Special Attendance Requirement.

12.6.3.1. A practitioner whose patient's clinical course of treatment, or for any other reason, is scheduled for discussion at a Clinical Department or other Committee meeting shall be so notified by the Chairperson of the appropriate Department or Committee at least 4 days prior to the meeting. The notification shall indicate the time and place of the meeting.

12.6.3.2. Failure of a practitioner to attend any meeting with respect to which notice was given that attendance was mandatory, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct, as provided by these Bylaws, Rules and Regulations. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Governing Board, if necessary. In all other cases, if the practitioner makes a timely request for postponement supported by an adequate reason that their absence will be unavoidable, such presentation may be postponed by the Chief of Staff, or by the MEC if the Chief of Staff is involved, until not later than the next Committee or Department meeting. Otherwise the pertinent clinical information available shall be presented and discussed as scheduled.

SECTION 7: NONVOTING EX - OFFICIO MEMBERS

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

SECTION 8: CONDUCT OF MEETING

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

SECTION 9: APPLICATION FEES

12.9. The Medical Executive Committee shall establish the amount of application and reapplication fees, if any, for each category of the Medical Staff. Medical Staff application fees shall be separately accounted for and shall be used for purposes of the Medical Staff, including payment of a stipend to the Chief of Staff and other Medical Staff personnel as approved by the MEC.

SECTION 10: CONFIDENTIALITY OF INFORMATION

12.10.1. 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 MEC, or Chief of Staff, 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.

12.10.2. Breach of Confidentiality. Effective Peer Review activity, including the consideration of the qualification of an application for Medical Staff membership or the consideration of Ongoing or Focused Professional Practice Evaluation, requires candour. Accordingly, any breach of the confidentiality of records, discussions and deliberations of the Medical Staff, including the 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.

12.10.3. Immunity. Each representative of the Hospital and every member of the Medical Staff, acting in good faith and in accordance with these Bylaws, Rules and Regulations, 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 their duties in connection with:

12.10.3.1. an application for Medical Staff privileges

12.10.3.2. providing information to Hospital regarding a practitioner's conduct and competence

12.10.3.3. participation in Peer Review activity pursuant to these Bylaws, Rules and Regulations

ARTICLE 13

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AMENDMENT AND ADOPTION OF BYLAWS, RULES AND REGULATIONS

SECTION 1: MEDICAL STAFF RESPONSIBILITY

13.1. The Medical Staff (through its Bylaws Committee and the MEC) shall have the initial responsibility to formulate, adopt and recommend to the Governing Board Medical Staff Bylaws, Rules and Regulations, and amendments thereto, which shall be effective when approved by the Governing Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing quality patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Governing Board and with the community.

SECTION 2: BYLAWS AMENDMENTS

13.2.1. Review of Bylaws. These Bylaws shall be reviewed periodically by the MEC or the Bylaws Committee and amended as necessary to reflect current operations or requirements of accreditation bodies or regulatory enforcement authorities.

13.2.2. Mechanism for Amendment. These Bylaws may be amended by:

13.2.2.1. an affirmative vote of the Medical Staff at a meeting. If there is not a quorum, then a request for vote may be sent to all voting members of the Medical Staff electronically. This vote will follow a recommendation of the MEC but must occur prior to submission for, approval of the Governing Board. Votes are to be held at the earliest quarterly Medical Staff meetings, or at a special meeting called for a vote on Bylaw amendment(s), or

13.2.2.2. the Medical Staff directly upon 2/3 affirmative vote of the voting Medical Staff at a meeting at which there is a quorum followed by approval of the Governing Board. If there is not a quorum, the a request for vote may be sent to all voting member of the Medical Staff electronically.

13.2.3. Effective Date of Amendment. An amendment shall be effective following an affirmative vote of the Medical Staff and approval of the Governing Board.

13.2.4. MEC Authorized to Make Certain Changes. The MEC shall be authorized to amend the Bylaws without the requirement of first convening a meeting of the Medical Staff and seeking Governing Board approval only under two circumstances:

13.2.4.1. to correct typographical errors and make other non-substantive clerical changes

13.2.4.2. to make changes necessary to meet Federal or State requirements. Amendments made pursuant to this authority shall be promptly made available to the Governing Board and the Medical Staff

13.2.5. Communication of Text. The text of all proposed amendment to the Bylaws (other than the text of amendment proposed by the Medical Staff directly) shall be made available to the Medical Staff at least 10 days before a meeting of the Medical Staff to vote on the proposed revision. The text of amendments adopted by the Medical Staff and approved by the Governing Board shall be provided to the Medical Staff immediately following final adoption by the Governing Board.

13.2.6. No Unilateral Amendment. The Bylaws may not be unilaterally amended by the Medical Staff or the Governing Board.

SECTION 3: MEDICAL STAFF RULES AND REGULATIONS

13.3.1. The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically and in greater detail the general principles found within these Bylaws. The Rules and Regulations shall relate to the proper conduct of the Medical Staff organizational activities and will embody the specific standards and level of practice that are required of each Medical Staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the Hospital.

13.3.2. 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 Bylaws as may be necessary.

13.3.3. The Rules and Regulations of the Medical Staff may be amended by a vote of the MEC at a meeting at which there is a quorum. Any member of the Medical Staff desiring to submit a proposed amendment of the Rules and Regulations directly to the Governing Board for approval shall submit a copy of the proposed amendment to the MEC at least 40 days in advance of the Governing Board meeting.

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

13.3.5. The MEC shall 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 Medical Staff shall be given immediate notice of such 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.

SECTION 4: OTHER MEDICAL STAFF GOVERNANCE DOCUMENTS, POLICIES AND PROCEDURES

13.4.1. The development and revision of all Medical Staff Governance Documents including Medical Staff policies and procedures, 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.

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

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

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

13.4.1.4. There shall be timely communication to the Medical Staff as a whole of the intent to develop or revise Medical Staff Governance Documents.

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

13.4.1.6. All Governance Documents, including policies, are subject to approval by the Governing Board.

13.4.2. The Medical Staff may, by affirmative vote at a meeting at which a quorum is present, propose a policy, or amendment to a policy, to the Governing Board directly for its consideration. Any member of the Medical Staff desiring to submit a proposed policy directly to the Governing Board for consideration shall submit a copy of the proposed policy or amendment to the MEC at least 40 days in advance of submitting the proposal to the Governing Board.

SECTION 5: RELATIONSHIP TO BYLAWS

13.5. In the event there is a discrepancy or conflict between the Bylaws and any Rules and Regulations, the Bylaws shall supersede the Rules and Regulations. In the event there is a discrepancy or conflict between the Bylaws, Rules and Regulations and any Hospital policies and procedures pertaining to the Medical Staff, the Bylaws, Rules and Regulations shall supersede those Hospital policies and procedures.

ARTICLE 14

OHCA

SECTION 1

14.1. 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.

SECTION 2

14.2. 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.

These Bylaws were updated for printing on:

_____	_____
CHIEF OF STAFF	DATE
_____	_____
PRESIDENT/CEO	DATE
_____	_____
CHAIRPERSON OF THE BOARD	DATE