MEDICAL STAFF BYLAWS/RULES AND REGULATIONS
OF
Grace Medical Center

P R E A M B L E

WHEREAS, *Grace Medical Center*, hereinafter referred to as "Hospital", is operated by Lubbock Heritage Hospital, LLC. hereinafter to as "Corporation", a private corporation organized under the laws of the state of Texas and is lawfully doing business in Texas, and is not an agency or instrumentality of any state, county or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board of Managers; and

WHEREAS, the cooperative efforts of the Medical Staff, management and the Board of Managers are necessary to fulfill these goals.

NOW, THEREFORE, the practitioners practicing in Grace Medical Center hereby organize themselves into a Medical Staff conforming to these Bylaws.

DEFINITIONS

1. "Active Staff" members shall be fully licensed doctors of medicine or osteopathy in the state of Texas that have the privilege of admitting patients, holding office and voting. "Courtesy Staff" members shall be those fully licensed doctors of medicine or osteopathy in the state of Texas that have the privileges of admitting patients in accordance with these Bylaws.

2. "Allied Health Professional" or "AHP" means an individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital. Such AHPs shall include, without limitation, PA-Cs, CRNAs, Psychologists, Podiatrists, and other such professionals. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

3. "Board" means the Board of Managers of the Grace Medical Center.

4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other applicable specialty boards.

5. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital; or his/her designee.

6. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

7. "Clinical Privileges" means the Board's recognition of the practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

8. "Corporation" means Lubbock Heritage Hospital, LLC.

9. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

10. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

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

12. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a practitioner's Clinical Privileges are adversely affected by a determination based on the practitioner's professional conduct or competence.
    The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix "A" hereto.

13. “Hospital” means Grace Medical Center.

14. “Licensed Independent Practitioner” means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted Clinical Privileges.

15. “Medical Executive Committee" or “MEC” means the Executive Committee of the Medical Staff.

16. "Medical Staff" means the formal organization of practitioners who have been granted Privileges by the Board to attend patients in the Hospital.

17. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan and such other policies as may be adopted by the Medical Staff subject to the approval of the Board.

18. "Medical Staff Year" means Calendar Year.

19. "Member" means a practitioner who has been granted Medical Staff membership and Clinical Privileges pursuant to these bylaws.

20. “Oral and Maxillofacial Surgeon” means an individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

21. “Organized Medical Staff” means the entity that is comprised of al the physicians, dentists, oral maxillofacial, podiatrists and other licensed independent practitioners who are granted medical staff membership.

22. "Physician" means a doctor of medicine or doctor of osteopathy who is properly licensed to practice medicine in Texas.

23. "Practitioner" means a physician, podiatrist or dentist who has been granted Clinical Privileges at the Hospital.

24. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other hospital and Medical Staff policies.

25. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

26. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital. Granting of Privileges to those (off-site) providers would be an exception from the 50 mile rule.

ARTICLE I
NAME

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

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;

2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other performance improvement activities in accordance with the Hospital's performance improvement program;

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs authorized to practice in the Hospital through delineation of Clinical Privileges, on-going review and evaluation of each practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;

2.1(e) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

2.1(f) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;

2.1(g) To promulgate, maintain and enforce Bylaws and rules and regulations for the proper functioning of the Medical Staff;

2.1(h) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO;

2.1(i) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(j) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

2.1(k) To accomplish its goals through appropriate committees.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Ensuring that practitioners cooperate with each other in caring for patients in the Hospital;

2.2(b) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and AHPs authorized to practice in the Hospital, by taking action to:

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of Clinical Privileges and assurance that all individuals with Clinical Privileges provide services within the scope of individual Clinical Privileges granted;

(3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital;

(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPS;

(6) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted;

(7) Develop, administer and enforce these Bylaws, the rules and regulations of the staff and other Hospital policies related to medical care;

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;

(9) Ensure that the functions delineated in Section 12.5(b) of these Bylaws are performed by appropriate standing or ad hoc committee of the Medical Staff; and

(10) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix "B" hereto.

(11) Implement a process to identify and manage matters of disruptive physician behavior that is separate from the Medical Staff disciplinary function in accordance with the Disruptive Practitioner's Conduct Policy, which is incorporated herein and attached as Appendix "C" hereto.

2.2(c) Assisting the Board in maintaining the accreditation status of the Hospital;

2.2(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

2.2(e) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

2.3 DISCLOSURE OF PHYSICIAN OWNERSHIP

Each physician who is a Member of the Hospital's Medical Staff agrees, as a condition of continued Medical Staff membership or admitting Privileges, to disclose in writing to all patients, which the physician refers to the Hospital, any ownership or investment interest in the Hospital held by the physician or held by an immediate family member of the physician.

2.4 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each Member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff Members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the practitioner only such Clinical Privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she is a Member of the Medical Staff with appropriate Privileges.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in Texas, who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or Privileges which will adversely affect their services to the Hospital;

(4) Have professional liability insurance that meets the requirements of Section 14.2(i); and provides proof of coverage as part of credentialing;

(5) Are graduates of an approved college holding appropriate degrees;

(6) Have successfully completed an approved internship program or the equivalent where applicable;

(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(8) Show evidence every 2 years of CME credits as required by the state of Texas The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;

(9) Meet one of the following requirements, in addition to those listed above:

(i) Board certification; or

(ii) adequate progress toward Board certification. The determination of adequacy shall be made by the MEC and must be approved by the Board of Managers; or

(iii) demonstration to the satisfaction of the MEC and the Board of Managers, competency and training equal or equivalent to that required for Board certification.

(10) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(11) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other practitioners within the Hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular Clinical Privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of gender, race, age, creed, color, national origin, disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the Member's certification that he/she has in the past, and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Member of the Medical Staff shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Impaired Practitioner and Disruptive Practitioner's Conduct policies, Appendices "B" and "C" hereto), Rules & Regulations of the Medical Staff;

3.3(d) Discharge the staff, committee and Hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;

3.3(e) Cooperate with other Members of the Medical Staff, management, the Board of Managers and employees of the Hospital;

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws;

3.3(h) If, at any time, the Hospital does not have arrangements for the provision of Emergency Services, any physician on the Active Staff clinically treating patients shall take emergency call on a rotating basis with the other Active Staff Members;

3.3(I) Attest that he/she suffers from no health problems which could effect ability to perform the functions of Medical Staff membership and exercise the Privileges requested prior to initial exercise of Privileges, and participate in the Hospital drug testing program;

3.3(j) Abide by the ethical principles of his/her profession and specialty;

3.3(k) Refuse to engage in improper inducements for patient referral;

3.3(l) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community; and

3.3(m) Notify the CEO and Chief of Staff immediately if:

(1) His/Her professional licensure in any state is suspended or revoked;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or

(4) He/She has been excluded from any federal or state health program, including Medicare and Medicaid.

(5) Change in Privileges on any other Medical Staff

3.3(n) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such Privileges as may hereinafter be provided.

3.4(b) Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting of Medical Staff Privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years.

3.4(d) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current Staff Member or the granting of additional Privileges to a current Staff Member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

A Staff Member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave is granted, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement.

3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the Staff Member may request reinstatement of his/her Privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The Staff Member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the Member's Privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of Staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, Privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a Staff Member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a Member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning Staff Member.
Any new Privileges requested will be acted upon and monitored in similar fashion as if the Member were a new applicant.

(3) Reinstatement will ordinarily be automatic if a leave of absence is an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

(4) If a Member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Active, Courtesy, Consulting, Inactive and Honorary categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these Bylaws;

(2) Have an office and/or residence located within 50 miles of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least 12 patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or out patient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single Hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff Member shall be:

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

(2) To exercise such Clinical Privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the staff organization and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each Member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than 6 hours after admission or sooner if warranted by the patient's condition;

(3) Actively participate:

(i) in the performance improvement program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;

(ii) in supervision of other appointees where appropriate;

(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(v) in discharging such other staff functions as may be required from time-to-time

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

(5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of committees of which he/she is a Member.

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners, who:

(1) Meet the basic qualifications set forth in these Bylaws;

(2) Have an office and/or residence located within 50 miles of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another Member of the Staff with Privileges appropriate to the treatment provided;

(3) Do not admit or regularly participate in the care of more than 12 patients in a calendar year; and

(4) Are Members of the Active Staff of another hospital where he/she actively participates in the performance improvement program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff Member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a);

(2) Exercise such Clinical Privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the staff and any staff or Hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she shall not vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each Member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;
(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service; and
(3) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff shall consist of a special category of physicians each of whom is:

(1) because of Board certification, training and experience, recognized by the medical community as an authority within his/her specialty; or
(2) held outpatient admitting or 'grandfathered' Privileges at the Grace Ambulatory Surgery Center, prior to merger on January 22, 2009

4.4(b) <u>Prerogatives: Board Certified, Specialty Trained, or an Authority</u>

(1) Prerogatives of a Consulting Staff Member under this category shall be to:

(I) consult on patients only by request of an Active or Courtesy Staff Member; and

(ii) attend all meetings of the staff that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff Members under this category shall not in any circumstance admit patients to the Hospital or transfer patients from the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Consulting Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

(3) Consulting Staff Members under this category may provide an unlimited number of consultation reports/recommendations during a calendar year. However, Consulting Staff Members who have more than 50 "consult and treat" encounters shall be transferred to Active Staff.

4.4(c) <u>Responsibilities: Board Certified, Specialty Trained or an Authority</u>

Each Member of the Consulting Staff under this category shall assume responsibility, as requested by an Active, Courtesy Staff Member, for consultation and appropriate documentation thereof with regard to particular patients

4.4(d) <u>Prerogatives: 'Grandfathered'</u>

(1) Prerogatives of a 'Grandfathered' Consulting Staff Member shall be to:

(i) perform outpatient surgery only at the Grace Medical Center freeway campus; and

(ii) attend all meetings of the staff that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff 'grandfathered' Members shall not in any circumstance admit inpatients to the Hospital or transfer patients or be the physician of primary care or responsibility for any patient within the Hospital, except for those admitted at Grace Medical Center Freeway campus. Consulting Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.4(e) Responsibilities: 'Grandfathered'

Each Member of the Consulting Staff shall assume responsibility, as requested by an Active, Courtesy Staff Member, for consultation and appropriate documentation thereof with regard to particular patients.

4.5 HONORARY STAFF

4.5(a) Qualifications

The Honorary and Retired Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active Hospital services, but continue to demonstrate a genuine concern for the Hospital; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.
Honorary Staff Members shall not be required to meet the qualifications set forth in Section 3.2(a) of these Bylaws.

4.5(b) Prerogatives

(1) Prerogatives of an Honorary Staff Member shall be:

(i) attending by invitation any such meetings that he/she may wish to attend as a nonvoting visitor.

(2) Honorary Staff Members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Honorary Staff Members shall not hold office nor be eligible to vote in the Medical
Staff organization.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

Allied Health Professionals ("AHPs") shall be identified as any person(s) other than practitioners who are granted Privileges to practice in the Hospital and are directly involved in patient care. Such persons may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician.

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

(3) Have professional liability insurance in the amount required by these Bylaws;

(4) Provide a needed service within the Hospital; and

(5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

5.3(a) To exercise judgment within the AHP's area of competence, providing that a physician Member of the Medical Staff has the ultimate responsibility for patient care;

5.3(b) To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a Member of the Medical Staff; and

5.3(c) To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of practitioners and shall be granted Clinical Privileges relevant to the care to be provided. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. AHP Privileges and their reduction or termination shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP's grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto . A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP. The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board Members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

5.4(c) AHP Privileges shall automatically terminate upon revocation of the Privileges of the AHP's supervising physician Member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician Member's Privileges are significantly reduced or restricted, the AHP's Privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's Privileges shall be

unaffected by the termination of a given surgeon's Privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

5.4(d) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or Clinical Privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.5(c) Discharge any committee functions for which he/she is responsible;

5.5(d) Cooperate with Members of the Medical Staff, administration, the Board of Managers and employees of the Hospital;

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.5(f) Participate in performance improvement activities and in continuing professional education;

5.5(g) Abide by the ethical principles of his/her profession and specialty; and

5.5(h) Notify the CEO and the Chief of Staff immediately if:

(1) His/Her professional license in any state is suspended or revoked;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or

(4) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or Clinical Privileges.

(5) Change in status on any other Medical Staff.

5.5(i) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated committees shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff Privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. Gender, race, age, creed, color and national origin are not used in making decisions regarding the granting or denying of Medical Staff membership. A separate, confidential record shall be maintained for each individual requesting membership or Clinical Privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (Note: DEA registration/controlled substance certificates are required for all practitioners, except Pathologists and applicable Allied Health Practitioners), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. No application fee or Medical Staff dues shall be assessed. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

 (i) to be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges; and

 (ii) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or Clinical Privileges.

(b) Administrative Remedies: A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or Clinical Privileges;

(c) Criminal Charges: Any current criminal charges pending against the applicant and any past convictions or pleas. The practitioner shall notify the CEO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(d) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;

(e) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the Privileges requested. In instances where there is doubt about an applicants' ability to perform Privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board;

(f) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the Chief of Staff within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The Chief of Staff shall be responsible for notifying the MEC of all such actions;

(g) Education: Detailed information concerning the applicant's education and training.

(h) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

(i) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 6.3(b) and (c);

(j) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:

(i) membership/fellowship in local, state or national professional organizations;

(ii) specialty Board certifications;

(iii) license to practice any profession in any jurisdiction;

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists and applicable Allied Health);

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges; or

(vi) the practitioner's management of patients which may have given rise to investigation by the state medical board; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.

(k) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;

(l) References: The names of at least three (3) practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, and clinical ability and current competence, ethical character and ability to exercise the Privileges requested and to work with others;

Peer recommendation includes written information regarding the practitioner's current:
Medical/clinical knowledge
Technical and clinical skills
Clinical judgment
Interpersonal skills
Communication skills
Professionalism

(m) Request: Specific requests stating the staff category and specific Clinical Privileges for which the applicant wishes to be considered;

(n) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

(o) Photograph: A recent, wallet sized photograph of the applicant;

(p) Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years; and

(q) Citizenship Status: Proof of United States citizenship or legal residency.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff appointment or reappointment and Clinical Privileges may obtain an application form therefore by submitting his/her written request for an application form to the Medical Staff Coordinator

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and Clinical Privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the Clinical Privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application; and

(5) Pledges to provide continuous care for his/her patients treated in the Hospital;

(6) Agrees to be bound by the statements described in Section 6.3(c).

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking Privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or Clinical Privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or Clinical Privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and Clinical Privileges.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment or Clinical Privileges, including temporary Privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of Clinical Privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other Hospital, Medical Staff, service or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff.

The term "third parties" means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that:

(1) Medical Staff appointments at this Hospital are not a right;

(2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations;

(3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final;

(4) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and

(5) appointment and continued Clinical Privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital. Appointment and continued Clinical Privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that:

(1) I will be provided a copy of the Medical Staff Bylaws and such hospital policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules & regulations of the Medical Staff presently in force; and

(2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such Bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise Clinical Privileges at the Hospital.

If appointed or granted Clinical Privileges, I specifically agree to:

(1) refrain from fee-splitting or other inducements relating to patient referral;

(2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;

(3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services;

(4) seek consultation whenever necessary;

(5) abide by generally recognized ethical principles applicable to my profession;

(6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and

(7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) **Submission of Application & Verification of Information**

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the Medical Staff Coordinator. The application shall be returned to the practitioner and shall not be processed further if one (1) or more of the following applies:

(1) Not Licensed. The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the practitioner has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or

(3) Exclusive Contract or Moratorium. The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the practitioners' specialty; or

(4) Inadequate Insurance. The practitioner does not meet the liability insurance coverage requirements of these Bylaws; or

(5) Ineligible for Medicare Provider Status. The practitioner has been excluded, suspended or debarred from any government payer program; or

(6) No DEA number. The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence with 50 miles of the Hospital; or

(8) Application Incomplete. The practitioner has failed to provide any information required by these Bylaws or requested on the application or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application. The refusal to further process an application form for any of the above reasons shall

not entitle the practitioner to any further procedural rights under these Bylaws.

In the event that none of the above apply to the application, Medical Staff Coordinator shall promptly seek to collect or verify the references, licensure and other evidence submitted. Medical Staff Coordinator. shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification.

Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of Privileges, at reappointment or renewal or revision of Clinical Privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) **Description of Initial Clinical Privileges**

Medical Staff appointments or reappointments shall not confer any Clinical Privileges or rights to practice in the hospital. Each practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those Clinical Privileges specifically granted by the Board. The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the Clinical Privileges he/she requests.

6.3(f) **Credentials Committee Action**

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and Clinical Privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, Clinical Privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any

minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(g) <u>Medical Executive Committee Action</u>

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the Privileges requested, the MEC may request an additional evaluation. The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and Clinical Privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

6.3(h) <u>Effect of Medical Executive Committee Action</u>

(1) <u>Deferral:</u> Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified Clinical Privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same. In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

(2) <u>Favorable Recommendation:</u> When the recommendation of the MEC is favorable to the applicant, Medical Staff Coordinator**.** shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Credentials Committee. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) <u>Adverse Recommendation:</u> When the recommendation of the MEC is adverse to the applicant, Medical Staff Coordinator shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the

purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested Clinical Privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan.

6.3(i) **Board Action**

(1) Decision; Deadline. The Board of Managers may accept, reject or modify the MEC recommendation. The Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Managers shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

(2) Favorable Action. In the event that the Board of Managers' decision is favorable to the applicant, such decision shall constitute final action on the application. Medical Staff Coordinator shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested Clinical Privileges, shall constitute a favorable action even if the exercise of Clinical Privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of Clinical Privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested Clinical Privileges.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board of Managers' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan. The CEO or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Board of Managers' written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan.

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

6.3(k) **Interview**

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(l) **Reapplication After Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the

grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

6.3(m) **Time Periods for Processing**

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The Medical Staff Coordinator shall transmit a completed application to the Credentials Committee upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the practitioner has failed to provide requested information needed to complete the verification process.

6.3(n) **Denial for Hospital's Inability to Accommodate Applicant**

A decision by the Board to deny staff membership, staff category assignment or particular Clinical Privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the Hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the Hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the Medical Staff Coordinator shall promptly so inform the applicant of the opportunity by special notice. Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of a practitioner's present staff appointment, the Medical Staff Coordinator shall provide the practitioner a reapplication form for use in considering reappointment. The Staff Member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the Member's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the Staff Member for the Privileges sought on reappointment;

(2) License: Current licensure;

(3) Health Status: Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of staff membership or to exercise the Privileges requested;

(4) Previous Affiliations: The name and address of any other health care organization or practice setting where the Staff Member provided clinical services during the preceding appointment period;

(5) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations during the preceding appointment period;

(6) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty Board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges; or

(vi) the practitioner's management of patients which may have been given rise to investigation by the state medical board; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(7) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(8) Criminal Charges: Any current criminal charges pending against the applicant and any convictions or pleas during the preceding appointment period. The practitioner shall notify the CEO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(9) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;

(10) Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years during the preceding appointment period;

(11) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws. Each practitioner must, at all times, keep the Medical Staff Coordinator informed of changes in his/her professional liability coverage;

(12) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by the Department Chairperson, and results from the performance improvement process of the Medical Staff. Practitioners, including those Members of the Courtesy Staff, who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing quality profiles and such other documentation

from other facilities where the practitioner has actively practiced; Practitioners who refer their patients to a Hospitalist or other types of admitting physicians for inpatient treatment may continue as Members of the Courtesy Staff, as long as the respective Department Chairs and the Credentials Committee review the applicable individual's credentials file and recommend continued membership in the Courtesy Staff category. The respective Department Chairs or the Credentials Committee may request one or more letters of recommendation from peers in the practitioner's same specialty and they may also seek secondary sources of physician performance information from other hospitals, where the practitioner holds Privileges. Members of the Courtesy Staff who admit directly to the Hospital during their appointment period are subject to Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). Focused Professional Practice Evaluation (FPPE) may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individual involved in the care of each patient, including consulting physicians, assistants at surgery, nursing or administrative personnel.

A period of Focused Professional Practice Evaluation (FPPE) is implemented for all initially requested Privileges, whether for Staff initially granted Privileges, or for newly granted Privileges for current Staff Members.

Courtesy Staff Members who are clinically involved in more than twelve (12) patients annually are automatically converted to Active Medical Staff. Members of the Active Medical Staff are also subject to Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). The criteria used in the ongoing professional practice evaluation may include the following:

1. Review of operative and other clinical procedures(s) performed and their outcomes;
2. Pattern of blood and pharmaceutical usage:
3. Requests for tests and procedures;
4. Length of stay patterns;
5. Morbidity and mortality data;
6. Practitioner's use of consultants;
7. Other relevant criteria as determined by the Medical Executive Committee of the Medical Staff.

The information used in the ongoing professional practice evaluation may be acquired through the following:

1. Periodic chart review;
2. Direct observation;
3. Monitoring of diagnostic and treatment techniques;

4. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel.

The Ongoing Professional Practice Evaluation (OPPE) of Members of the Medical Staff shall occur annually; it will be administered by the respective Chairs of the Departments of Medicine and Surgery, overseen by the Credentials Committee of the Medical Staff, and controlled by the Medical Executive committee. The Hospital Board will receive the recommendations of the Medical Executive Committee regarding individual appointments and reappointments of Members to the Medical Staff.

Active Medical Staff Members who are clinically involved in twelve (12) or fewer patients annually are automatically transferred to Courtesy Staff.

(13) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c); and

(14) Information on Ethics/Qualifications: Such other specific information about the Staff Member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital.

(15) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of Privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least two (2) practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the Privileges requested and to work with others;

Upon renewal of Privileges, when insufficient practitioner-specific data are available, the Medical Staff obtains and evaluates peer recommendations.

Peer recommendation includes written information regarding the practitioner's current:
Medical/clinical knowledge
Technical and clinical skills
Clinical judgment
Interpersonal skills
Communication skills
Professionalism

Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

6.4(c) **Verification of Information**

The Medical Staff Coordinator. shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the Staff Member's professional activities, performance and conduct in the Hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the Medical Staff Coordinator. shall transmit the Reapplication Form and supporting materials to the Chairman of the Credentials Committee.

An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) **Action on Application**

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

6.4(e) **Basis for Recommendations**

Each recommendation concerning the reappointment of a Staff Member and the Clinical Privileges to be granted upon reappointment shall be based upon such Member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and with patients, results of the Hospital monitoring and evaluation process, including practitioner specific information compared to aggregate information from Performance Improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Staff Member may, either in connection with reappointment or at any other time, request modification of his/her staff category or Clinical Privileges, by submitting a written application to the Administration on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 6.4 for

reappointment. No Staff Member may seek modification of Privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Modifications of staff category or Clinical Privileges shall remain in effect until the next regularly scheduled reappointment period.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A practitioner who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and Clinical Privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or Staff Member.

6.6(b) Requirements for Service

In approving any such practitioners for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff membership and Clinical Privileges. The Fair Hearing does not apply in this case.

6.7 MEDICAL STUDENTS, RESIDENTS, AND FELLOWS.

6.7(a) General Requirements

Medical Students, Residents, and Fellows rotating through the Hospital will be credentialed and receive delineated Privileges from the affiliated University; credentialing information shall be available to the Hospital upon request and as needed by the Medical Staff for making training assignments and in performance of their supervisory functions. Competency, and their duties will be established in the Affiliation Agreement between the University and the Hospital. Medical Students may not treat patients in the Hospital and shall be assigned for observation only, unless they have been granted Privileges to scrub in and assist in surgery and in accordance with the written training protocols developed by the respective clinical service and supervising physician and reviewed and approved by the Hospital

MEC in conjunction with the Residency Training Program. Residents' and Fellows' Privileges will be delineated in or attached to the Affiliation Agreement contract. The mechanism by which Medical Students, Residents and Fellow are supervised by Medical Staff Members in carrying out their patient care responsibilities are defined in the Hospital's Medical Staff Rules and Regulations. These duties will be consistent with the scope of their medical licensure and education and they shall be under the direct supervision or direction of a Member of the Medical Staff. At all times, Medical Students, Residents, and Fellows shall abide by all applicable provisions of these Medical Staff Bylaws and the Hospital's Medical Staff Rules and Regulations, as well as Hospital policies. Except as otherwise provided in the applicable Affiliation Agreement, Medical Students, Residents, and Fellows shall be subject to limitation or termination of their ability to function at the Hospital at any time at the discretion of the Chief of Staff or the CEO.

6.7(b) Review and Approval of University Affiliation Agreements

All Affiliation Agreements will be reviewed by the Chief of Staff, who will make a recommendation for approval or disapproval. The Board of Managers will determine final approval or denial of the Affiliation Agreement.

6.7(c) Activities Outside of the Affiliation Agreement

Any activities by Residents and Fellows that are outside the responsibility or duties covered by the Affiliation Agreement, or where they are practicing independently, will require full credentialing and privileging as prescribed in these Medical Staff Bylaws.

6.7(d) Termination.

Subject to a Resident or Fellow obtaining full credentialing and privileging as provided in Section 6.7(c), Medical Students, Residents, and Fellows shall not be entitled to any rights, Privileges, or to The Fair Hearing or appeal rights under these Medical Staff Bylaws.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those Clinical Privileges or services specifically granted to him/her by the Board. Said Privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific Privileges and limitations for each category of practitioner, and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. The request for specific Privileges must be supported by documentation demonstrating the practitioner's qualifications to exercise the Privileges requested. A request by a Staff Member for a modification of Privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of Clinical Privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner's education, training, current competence, including documented experience in the requested treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For practitioners who have not actively practiced at the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(12) herein. In addition, those practitioners seeking Clinical Privileges (except those seeking emergency Privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of Privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical Privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a Staff Member.

7.2(c) Procedure

All requests for Clinical Privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new Privileges are requested.

7.2(d) Limitations on Privileges

The delineation of an individual's Clinical Privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for Clinical Privileges from dentists and oral surgeons shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists and oral surgeons shall be under the overall supervision of the Chief of Surgery, however, other dentists and/or oral surgeons shall participate in the review of the practitioner through the performance improvement process. All dental patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician Member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

7.4(a) Temporary Privileges - Applicant

Temporary Privileges may only be granted in two circumstances: to fulfill an important patient care, treatment, and service need, and when a new applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board. Only the CEO or his/her designee, upon recommendation of the Chief of Staff, or Chairperson of the MEC may grant such Privileges upon completion of the appropriate application, consent and release, proof of current licensure, DEA/DPS certificates, appropriate malpractice insurance, current competence, ability to perform the Privileges requested, relevant training and completion of the required Data Bank query. When Temporary Privileges are granted to fulfill an important patient care, treatment and service need, the Organized Medical Staff verifies current licensure and current competence. Temporary Privileges for new applicants are granted for no more than 120 days.

7.4(b) Temporary Privileges – Non-Applicant

Temporary Privileges may be granted to non-applicants by the Chief Executive Officer, or his/her designee, upon recommendation of the Chief of Staff, when there is an important patient care, treatment or service need. Specifically, temporary Privileges may be granted for situations such as the following: (i) the care of a specific patient; or (ii) when necessary to prevent a lack or lapse of services in a needed specialty area. The following factors shall be considered

and verified prior to the granting of Temporary Privileges in these situations: completion of the appropriate application, consent and release, proof of current licensure, DEA/DPS certificates, appropriate malpractice insurance and completion of the required Data Bank query. The granting of Clinical Privileges in these situations shall not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the Chief Executive Officer and Chief of Staff.

7.4(c) <u>One-Case Privileges</u>

Upon receipt of a written request, an appropriately licensed person who is not an applicant for membership may be granted Temporary Privileges for the care of one (1) patient. Such Privileges are intended for isolated instances in which extension of such Privileges are shown to be in an individual patient's best interest, and no practitioner shall be granted one-case Privileges on more than five (5) occasions in any given year. The letter approving such Privileges shall include the name of the patient to be treated and the specific Privileges granted. Practitioners granted one-case Privileges shall attend the patient for whom Privileges were granted within thirty (30) days of the request for one-case Privileges. If a given practitioner exceeds the five (5) case requirement, such person shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Prior to any award of one-case Privileges, the practitioner must submit a copy of current license, DEA certificate, proof of appropriate malpractice insurance and curriculum vitae and the CEO or his/her designee must obtain telephone verification of the physician's Privileges at his/her primary hospital.

7.4.(d) <u>Locum Tenens</u>

Upon receipt of a written request, an appropriately licensed person who is serving as locum tenens for a Member of the Medical Staff may, without applying for membership on the staff, be granted Temporary Privileges for an initial period not to exceed thirty (30) days. Such Privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. The Data Bank query must be completed prior to any award of locum tenens Privileges pursuant to this section. Further, prior to award of locum tenens Privileges, the applicant must submit, a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone verification of Privileges at the practitioner's primary hospital. The letter approving locum tenens Privileges shall identify the specific Privileges granted.

Members of the Medical Staff seeking to provide coverage through locum tenens physicians shall, where possible, advise the Hospital at least thirty days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for

appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(e) Conditions

Temporary. one-case and locum tenens Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the Privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such practitioner be admitted upon dual admission with a Member of the Active Staff. Before temporary or locum tenens Privileges are granted, the practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her Privileges.

7.4(f) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the Privileges granted, the Chief of Staff and the CEO may terminate any or all of such practitioner's temporary, one-case or locum tenens Privileges. Where the life or well-being of a patient is endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner.

7.4(g) Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary, one-case or locum tenens Privileges or because of any termination or suspension of such Privileges.

7.4(h) Term

No term of temporary or locum tenens Privileges shall exceed a total of one hundred and twenty (120) days with the exception of non-applicants with Temporary Privileges.

7.5 EMERGENCY & DISASTER PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger. A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available Medical Staff Members is not adequate to provide all

clinical services required by the citizens served by this facility. In the case of an emergency or disaster as defined herein, any practitioner, to the degree permitted by his/her license and regardless of staff status or Clinical Privileges, shall, as approved by the CEO or his/her designee or the Chief of Staff, Vice-Chief of Staff, or Department Chairperson, be permitted to do, and be assisted by Hospital personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed. Disaster Privileges may be granted by the above-referenced individuals upon CEO or Chief of Staff when the emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Presentation of a current license to practice and a valid ID issued by a state, federal or regulatory agency shall be required before such Privileges are granted. The CEO and/or Chief of Staff are not required to grant such Privileges to any individual and are expected to make such decisions on a case-by-case basis. Individuals who are granted disaster Privileges As soon as possible after disaster Privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for Temporary Privileges when required to address an emergency patient care need. If, due to extraordinary circumstances, primary source verification of volunteer licensed independent practitioners cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible. The Medical Staff oversees the performance of each volunteer licensed independent practitioner and based on its oversight, determines within 72 hours of the practitioner's arrival if granted Disaster Privileges should continue.

7.6 TELEMEDICINE

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board of Managers regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.6(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "telemedicine physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. If the telemedicine physician's site is also accredited by Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which Privileges are being sought in the Hospital, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with Clinical Privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive to Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) Members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital's impaired physician practitioner policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

(5) Recommending reduction, suspension or revocation of Clinical Privileges;

(6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

8.1(e) <u>Procedural Rights</u>

Any action by the MEC pursuant to Section 8.1(d)(4), (5) or (6) (where such action materially restricts a practitioner's exercise of Privileges) or any combination of such actions, shall entitle the practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the Member has either waived his/her right to a hearing or completed the hearing.

8.1(f) <u>Other Action</u>

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a practitioner's exercise of Privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) <u>Board Action</u>

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the practitioner to the procedural rights as specified in the Fair Hearing Plan.

8.2 <u>SUMMARY SUSPENSION</u>

8.2(a) <u>Criteria & Initiation</u>

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these Bylaws or other Hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical

Privileges immediately upon imposition. Subsequently, the CEO and Chief of Staff shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner. Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate Clinical Privileges to provide continued medical care for the suspended practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician. It shall be the duty of all Medical Staff Members to cooperate with the Chief of Staff and the CEO in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the practitioner's Privileges are not materially restricted, the matter shall be closed and no further action shall be required. If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension. Upon ratification of the summary suspension or modification which materially restricts the practitioner's Clinical Privileges, the practitioner shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 ADMINISTRATIVE CORRECTIVE ACTION

8.3(a) Criteria for Initiation

Whenever a practitioner violates Hospital policies, rules or regulations, or acts in a manner disruptive to Hospital operations, or in such a manner as to endanger the assets of the Hospital because of financially imprudent actions not justified by patient care considerations, administrative corrective action may be initiated by the Hospital CEO, by the Chairman of the Board of Managers, or by the Board. Such action shall be taken pursuant to this section, rather than Section 8.1 or 8.2, only in those instances in which disruptive or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of Hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment.

8.3(b) Documentation of Behavior

Physicians and Hospital employees who observe disruptive behavior by a physician shall document the behavior, and shall submit such written documentation to the CEO. In performing all functions hereunder, the CEO and all designees acting on his behalf shall be deemed authorized agents of the Board and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

8.3(c) Administrative Action

The CEO and Chief of Staff shall meet with the physician and if the CEO and Chief of Staff determine that the complaint has merit, he/she will emphasize during the meeting that such conduct is inappropriate, and that further such conduct will result in formal action. A follow-up letter shall be sent to the physician memorializing the discussion of the incident. If the physician's disruptive behavior continues, the Board Chairperson, Chief of Staff and CFO shall meet with and advise the physician that such conduct is intolerable and must stop. The physician will be informed that the meeting constitutes the final warning prior to formal action. The meeting will be followed with a letter reiterating the warning, which shall become a part of the physician's permanent file. Nothing herein shall be deemed to require the occurrence of the above two (2) meetings prior to institution of formal corrective action in the event that the action is sufficiently serious to justify.

8.3(d) Request & Notices

Upon occurrence of an additional incident after the above process, the Chief of Staff shall submit a formal request for corrective action to the Board of Managers. The request shall be submitted in writing and supported by reference to the specific activities or conduct which constitutes the grounds for the request.

8.3(e) Investigation by the Board

The Chief of Staff shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprized of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary; the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.3(f) Board Action

Within sixty (60) days following receipt of the report, the Board shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking Clinical Privileges;

(5) Reducing staff category or limiting prerogatives; or

(6) Suspending or revoking staff membership.

8.3(g) Procedural Rights

Any action by the Board pursuant to Section 8.3(f)(4), (5) or (6), or (f)(3) (where such action materially restricts a practitioner's exercise of Privileges) or any combination of such actions, shall entitle the practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The action will not become final until the practitioner has either waived his/her right to a hearing or completed the hearing.

8.3(h) Other Action

If the Board's action is as provided in Section 8.3(f) (1) and (2), or (f) (3) (where such action does not materially restrict a practitioner's exercise of Privileges), such action shall become the final action of the Board, and the practitioner shall not be entitled to the rights enumerated in the Fair Hearing Plan.

8.4 AUTOMATIC SUSPENSION

8.4(a) License

A Staff Member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Texas is revoked or relinquished, suspended or restricted shall immediately and automatically be suspended from the staff and practicing in the Hospital. The Member will not have the right of hearing or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for the suspended practitioner's patients.

8.4(b) Drug Enforcement Administration (DEA) Registration Number

Any practitioner (except a pathologist) whose DEA registration number/controlled substance certificate is revoked, or suspended or relinquished shall immediately and automatically be divested of his/her right to prescribe scheduled drugs, suspended from the staff and from practicing in the Hospital until such time as the registration is reinstated.

8.4(c) Medical Records

(1) Automatic suspension of a practitioner's Privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Notwithstanding the provision of Section 8.4(c)(1), any Staff Member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.4(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.4(d) Malpractice Insurance Coverage

Any physician unable to provide proof of current medical malpractice coverage in the amounts prescribed in these Bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

8.4(e) Exclusions/Suspension from Medicare

Any physician who is excluded from the Medicare program or any state government payor program will be automatically suspended.

8.4(f) Automatic Suspension - Fair Hearing Plan Not Applicable

No Staff Member, whose Privileges are automatically suspended under this Section 8.4, shall have the right of hearing or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended practitioner's patients.

8.4(g) Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Chief of Staff informed of the names of Staff Members who have been suspended or expelled under Section 8.4.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and corrective action.

8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the practitioner's Privileges. Any of the following shall have the right to impose supervision: Chief of Staff, the CEO, or the Board.

8.7 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 6.3(c) of these Bylaws.

8.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a practitioner, it may in its discretion give the practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of Temporary Privileges, terms of probation, nor any other actions which do not materially restrict the practitioner's exercise of Clinical Privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING AHPS

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these Bylaws.

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) Chief of Staff;

(2) Vice-Chief of Staff;

(3) Immediate Past Chief of Staff.

10.1(b) Qualifications

Officers must be Members of the Active Staff at the time of nomination and election and must remain Members in good standing during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the Chief of Staff, the Past-Chief of Staff of the Medical Staff and the CEO. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the staff and when otherwise necessary to fill vacancies. Only Members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the Members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board of Managers, which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff or to be disruptive to the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff. Reasons for removal may include, but shall not be limited to violation of these Bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or Clinical Privileges and shall not be considered an adverse action.

10.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

10.1(h) Duties of Elected Officers

(1) Chief of Staff. The Chief of Staff shall serve as the Chief Medical Officer and principal official of the staff. As such he/she will:

(i) appoint multi-disciplinary Medical Staff committees;

(ii) aid in coordinating the activities of the Hospital administration and of nursing and other non-physician patient care services with those of the Medical Staff;

(iii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;

(iv) in concert with the MEC and Credentials Committee, develop and implement methods for credentials review and for delineation of Privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

(v) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Hospital management committees;

(vi) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;

(vii) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(viii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

(ix) serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;

(x) assist in coordinating the educational activities of the Medical Staff; and

(xi) serve as liaison for the Medical Staff in its external professional and public relations.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

(3) The Immediate Past Chief of Staff shall be a member of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

10.1(i) Conflict of Interest of Medical Staff Leaders

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, Chair or Vice- Chair of any department, officer of the Medical Staff, and/or Members of the Medical Staff who are also members of the Hospital's Board of Managers) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that Member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis. No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid

even the appearance of influencing the actions of any other Staff Member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff. Annually, on or before, each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the Member's status as a Medical Staff leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

4. Business practices that may adversely affect the Hospital or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made. Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member’s written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC. Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI

CLINICAL SERVICES

11.1 CLINICAL SERVICES

11.1(a) There shall be clinical services of medicine, surgery and such other services as may be established by unanimous vote of the MEC or added by amendment procedures as described in Article XV of these Bylaws.

11.2 SERVICE FUNCTIONS

The primary function of each service is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care. To carry out this overall function, each service chair shall:

11.2(a) Account to the department, Medical Executive Committee and Board for all professional and administrative activities within his/her department and particularly for the quality and safety of patient care rendered by members of the department.

11.2(b) Provide for the ongoing professional practice evaluation, and when appropriate focused practice evaluation of the clinical performance of all practitioners exercising clinical privileges within the department, and make recommendations concerning clinical privileges for each member of the department as appropriate.

11.2(c) Recommend the criteria for clinical privileges that are relevant to the care provided in the department.

11.2(d) Provide for the continuing review and investigation of the qualifications and conduct of all practitioners seeking or holding privileges in the department and make recommendations in a timely manner concerning all applications for Medical Staff Membership or clinical privileges within the department. Recommendations shall be based on criteria which include, but are not limited to, current licensure, relevant training and experience, ability to work in a cooperative and collegial manner with other health care providers, demonstrate current competence, the ability to perform the privileges requested and quality-of-care criteria.

11.2(e) Implement and maintain effective peer review, performance improvement and quality and patient safety activities within the department, including process measurement and assessment, investigating clinical performance and conducting and initiating any corrective action required.

11,2(f) Appoint, and when appropriate, remove, the members of all committees of the department and designate the chair of each committee.

11.2(g) Develop and enforce the Hospital and Medical Staff Bylaws, rules and regulations, and policies and procedures within the department that guide and support provision of services.

11.2(h) Work with Hospital administration with regard to all administrative matters, patient care issues, and nursing care issues related to the department.

11.2(i) Delegate duties of the chair to such individuals or committees in the department as the chair determines appropriate.

11.2(j) Supply references and recommendations required by other institutions or organizations for credentialing purposes.

11.2(k) Provide for the maintenance of complete and accurate minutes of all meetings of the department with the assistance of staff provided by Hospital.

11.2(l) Assess and recommend to the Medical Staff Executive Committee and the Hospital President/CEO of the Hospital, off-site sources for needed patient care, treatment and services not provided by the department or the organization.

11.2(m) Integrate the department into the primary functions of Hospital.

11.2(n) Coordinate and integrate inter-departmental and intra-departmental services.

11.2(m) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.

11.2(n) Make recommendations concerning a sufficient number of qualified and competent persons to provide care, treatment, and services.

11.2(o) When appropriate, make recommendations concerning the number, qualifications, and competence of department or service personnel who are not licensed independent practitioners, but who provide patient care, treatment, or services.

11.2(p) Help provide for the orientation and education for all persons in the department relative to department issues.

11.2(q) Recommend space and other resources needed by the department or service.

11.2(h) Make recommendations regarding the oversight and maintenance of quality control programs, as appropriate.

11.2(i) Make recommendations to the Credentials Committee, Medical Executive Committee and Hospital administration concerning any proposed new procedures and services, including the training, education and experience required for practitioners to exercise clinical privileges for new procedures or services.

15.2 **QUALIFICATIONS OF DEPARTMENT OFFICERS**

Each department chair shall be board certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process and shall be a member of the Active Staff in good standing.

ARTICLE XII
COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

12.1(c) All information pertaining to activities performed by the Medical Staff and its committees shall be privileged and confidential to the full extent provided by law.

12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;

(2) The Chief of Staff Elect;

(3) The Immediate Past Chief of Staff;

(4) Chiefs of Service; and

(5) The CEO, ex-officio, or his/her designee.

12.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings. All Active Medical Staff Members shall be eligible to serve on the MEC. The functions and responsibilities of the MEC shall include, at least the following:

(1) Receiving and acting upon committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of Clinical Privileges, staff category and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Recommending action to the CEO on matters of a medico-administrative nature;

(7) Developing and implementing programs for continuing medical education for the Medical Staff;

(8) Developing and implementing programs to inform the staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;

(9) Assuring regular reporting of performance improvement and other staff issues to the MEC and to the Board of Managers and making communicating findings, conclusions, recommendations and actions to improve performance to the Board regarding performance improvement processes and activities and appropriate Staff Members;

(10) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(11) Assuring an annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted;

(12) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital;

(13) Requesting evaluation of practitioners in instances where there is doubt about an applicant's ability to perform the Privileges requested. Initiating an investigation of any incident, course of conduct, or

allegation indicating that an practitioner to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or Clinical Privileges without limitation, further training, or other safeguards;

(14) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(15) Developing and monitoring compliance with these Bylaws, the rules and regulations, policies and other Hospital standards; and

(16) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of Privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated.

12.2(c) Meetings

The MEC shall meet as needed, but at least monthly and maintain a permanent record of its proceedings and actions.

12.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the Chief of the Medical Staff, when a majority of the MEC can be convened.

12.2(e) Conflict Resolution Between the Medical Staff and the Medical Executive Committee

(2) A Conflicts Resolution Committee shall be formed consisting of equal numbers of representatives of the Active Staff, designated by the Active Staff members and the MAC, appointed by the President of the Medical Staff. The Hospital President/CEO or designee shall be ex-officio non-voting members of any Conflicts Resolution Committee.

(3) The members of the Conflicts Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality, and in accordance with the Hospital's Conflict Management Resolution Policy.

(4) Any recommendation approved by a majority of both the Active Staff members and MAC representatives shall be submitted to the Board for consideration and subject to final Board approval. If agreement cannot be reached by a majority of the Active Staff members and MAC representatives, the members of the Conflicts Resolution Committee

shall individually or collectively report to the Board regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute.

(5 In the event of a dispute between leaders or segments of the Organized Medical Staff, the matter in dispute shall be resolved by the Conflicts Resolution Committee composed of an equal number of members representing opposing viewpoints who are appointed by the Medical Staff President or the MEC in accordance with the procedures in Section (4) and (5) of this Section 12.2 (e).

(6) In the event of a dispute between the Board and the Organized Medical Staff or the MEC, the matter in dispute shall be submitted to a Joint Conference Committee pursuant to Section 15.8 of these Bylaws.

(7) If deemed appropriate by the President of the Medical Staff and the Hospital President/CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

12.3 CREDENTIALS COMMITTEE

12.3(a) Composition

Composition shall consist of three (3) Active Staff Members, one who will serve as Chairman, and shall appoint the other two (2) Members.

12.3(b) Meetings

This committee shall meet at least quarterly or as required to perform its functions.

12.3(c) Functions

The functions of the Credentials Committee shall be to:

Moved functions to 12.5(b)

12.4 NOMINATING COMMITTEE

12.4(a) Composition

Composition shall consist of the Past Chief of Staff, Vice Chief of Staff and Current Chief of Staff who shall serve as presiding officer, and the CEO who shall serve as ex officio member.

12.4(b) Functions

Moved functions to 12.5(b)

12.4(c) <u>Meetings</u>

The Nominating Committee shall meet annually at least sixty (60) days prior to the annual meeting, maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Staff at least thirty (30) days prior to the annual meeting.

12.5 <u>MEDICAL STAFF FUNCTIONS</u>

12.5(a) <u>Composition of Committees</u>

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

12.5(b) <u>Functions</u>

The functions of the staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and other ambulatory care services;

(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate reviews;

(3) Conduct or coordinate utilization review activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;

(5) Develop and maintain surveillance over drug utilization policies and practices;

(6) Investigate and control nosocomial infections and monitor the Hospital's infection control program;

(7) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(8) Direct staff organizational activities, including staff Bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(9) Provide for appropriate physician involvement in and approval of the multi- disciplinary plan of care, and provide a mechanism to coordinate the care provided by Members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

(10) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, the Medical Staff has adopted an Impaired Practitioner Policy (attached hereto as Appendix "B" and incorporated herein by reference). The purpose of this policy is to provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The Impaired Practitioner Policy affords resources separate from the corrective action process to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff Members and providing appropriate advice, counseling or referrals;

(11) Provide leadership in activities related to patient safety;

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical Privileges:

(i) medical assessment and treatment of patients;

(ii) Use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process

(iii) use of medications, use of blood and blood components;

(iv) use of operative and other procedure(s);

(v) appropriateness of clinical practice patterns; and

(vi) significant departure from established patterns of clinical practice.

(vii) the use of developed criteria for autopsies

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;

(ii) coordination of care, treatment and services with other practitioners and Hospital personnel, as relevant to the care of an individual patient;

(iii) accurate, timely and legible completion of patients' medical records including history and physicals;

(iv) Patient satisfaction;

(v) Sentinel events; and

(vi) Patient safety.

(14) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence; and

(15) Recommend to the Board policies and procedures which define the circumstances requiring a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers;

(16) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

(17) Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;

(18) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of Clinical Privileges;

(19) Review, on a periodic basis, applications for reappointment including information regarding the competence of Staff Members; and as a result of such reviews make recommendations for the granting of Privileges and reappointments;

(20) Investigate any breach of ethics that is reported to it;

(21) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and

12.5(c) <u>Meetings</u>

These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

ARTICLE XIII
MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be held in November, at a date, time and place determined by the MEC.

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Service Chiefs;

(3) The election of officers and other officials of the Medical Staff when required by these Bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

13.2 REGULAR STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet bi-annually, the last meeting each year to be designated as the Annual Staff Meeting. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

13.2(c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by chief of Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

The voting Members of the Active Staff who are present at any staff meeting shall constitute a quorum for the transaction of all business before any action may be taken, but once found, the business of the meeting may continue and all actions taken thereafter shall be binding, even though less than a quorum may be present at a later time during the meeting excepting the amending of Bylaws where a quorum is required at the time of the vote at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) Committee Meetings

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if an unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 MINUTES

Minutes of all meetings shall be prepared by the Medical Staff Coordinator, or his/her designee, and shall include a record of attendance and the vote taken on each matter. Copies of such 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 shall be maintained. Complete and detailed minutes must be recorded and maintained.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Members of the Active Staff shall be required to attend 50 percent meetings of the Medical Staff. Absence for more than 50 percent of the regular meetings for the year without acceptable excuse may be considered as a resignation from the Active Staff. Members must also attend 50 percent of committee and departmental meetings in which they are a Member.

13.7(b) Absence from Meetings

Any Member who is compelled to be absent from any Medical Staff, Departmental or committee meeting shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence. Unless excused for a good cause, failure to meet the attendance requirements of these Bylaws shall be grounds for corrective action.

Reinstatement of a Staff Member whose membership has been revoked because of absence from meetings shall be made only on application and such application shall be processed in the same manner as an application for initial appointment.

13.7(c) Special Appearance

Any committee of the Medical Staff may request the appearance of a Medical Staff Member at a committee meeting when the committee is questioning the practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's Clinical Privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV
GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each Staff Member or affiliate in the Hospital. Such rules and regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

14.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted Clinical Privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than $200,000.00 per occurrence and $600,000.00 in the aggregate with a carrier reasonably acceptable to the Hospital, such insurance to be on an occurrence basis or, if on a claims made basis the practitioner agrees to obtain tail coverage covering his/her practice at the Hospital. CRNAs and AHPs shall be required to carry malpractice coverage no less than $100,000/$300,000. Each practitioner shall also inform the MEC and CEO of the details of such coverage annually. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

14.3 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO or his/her designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.4 CONSTRUCTION OF TERMS & HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these Bylaws.

14.5 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO or his/her designee.

14.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.6(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, Staff Members or AHPs, submitted, collected or prepared by any representative of the Hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

14.6(b) Release from Liability

No representative of the Hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or Member of the Staff, or who has exercised Clinical Privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

14.6(c) Action in Good Faith

The representatives of the Hospital, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

14.6(d) **Histories and Physicals.** A physician, oral maxillofacial surgeon, a physician assistant, or credentialed Independent Licensed Practitioner holding Privileges at the Hospital, must complete a physical examination and medical history for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration. A history and physical must be completed prior to any surgery or procedure requiring anesthesia services. A history and physical performed by a physician assistant or nurse practitioner must be signed by that individual and then authenticated and countersigned within twenty-four (24) hours, or prior to the patient undergoing surgery, by the attending physician. A history and physical performed within thirty (30) days

prior to hospital admissions may be used, as long as the medical record contains durable, legible practitioner documentation indicating:

The history and physical has been reviewed and is still current;

That an appropriate assessment was completed within 24 hours after inpatient admission or prior to surgery, whichever comes first, confirming that the necessity for the procedure or care is still present; and

That the patient’s condition has not changed since the history and physical was originally completed.

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

The Organized Medical Staff adopts and amends Medical Staff Bylaws and amendments. Adoption and amendment of Medical Staff Bylaws cannot be delegated. The Organized Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

15.2 REVIEW, ADOPTION, AMENDMENT OF BYLAWS

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws will be revised to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of majority of the Active Medical Staff members, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written notice, accompanied by the proposed Bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

15.2(b) Medical Executive Committee

With the vote of the Active Staff members in Section 15.2(a), the Medical Executive Committee may give tentative approval to implement the Medical Staff Bylaws up until the next Medical Staff meeting at which time the revisions to the Bylaws can be ratified, altered or denied. This approval by the Medical Executive Committee is subject to a unanimous vote of the members of the Medical Executive Committee who are present at the time the proposed Bylaws are considered, and provided a quorum is present according to the Medical Staff Bylaws.

15.2(c) Board

(1) Bylaw amendments approved by the MAC and two- thirds of the Active Staff members pursuant to Section 15.2(a) above, shall be forwarded to the Board, which shall approve, disapprove or approve with modifications.

(2) If the Board modifies any Bylaw amendment approved by the MAC and the Active Staff members pursuant to Section 15.2 (a) above, such amendment, as modified , shall be returned to the

MAC, which may accept or reject the modifications adopted by the Board.

(i) If the MAC accepts the modifications, the amendment shall be submitted to the Organized Medical Staff for approval or disapproval in accordance with Section 15.2 (a) above.

(ii) If the MAC rejects the modification, the amendment shall again be submitted to the Board, which may either approve or disapprove the amendment as approved and adopted by the MAC and the Organized Medical Staff pursuant to Section 15.2 (a) above.

(3) Bylaw amendments proposed to the Board by Organized Medical Staff upon majority of the Active Medical Staff members, who are present and voting at a meeting at which a quorum is present shall again be presented to the Board for final action along with any comments from the MAC.

(4) The MAC or the Board may require that any disputes regarding proposed Bylaws amendments be referred to a Joint Conference Committee for discussion and further recommendations to the MAC and the Board.

15.3 PROPOSED AMENDMENT OF BYLAWS , INITIATION AND COMMUNICATION

(1) Proposed amendments of the Bylaws may originate from a vote of majority of the Active Medical Staff members, who are present and voting at a meeting at which a quorum is present . When the Active Staff propose amendments and before it votes, it will communicate the proposed amendment to the Organized Medical Staff.

(2) Bylaw amendments may also be proposed to the Board by the Organized Medical Staff by majority of the Active Medical Staff members, who are present and voting at a meeting at which a quorum is present.

(3) Proposed Bylaw amendments introduced at the MAC may be sent to the Medical Staff Bylaws Committee for review and comment. All Bylaw amendments proposed by the Bylaws Committee shall be presented to the MAC which may approve, disapprove, or approve with modification, any proposed Bylaw amendment.

(3) All proposed Bylaw amendments approved by the MAC shall be submitted to the Active Staff for approval in accordance with Section 15.2(a) above.

(4) Any Bylaw amendment approved by the Active Staff shall again be presented to the Board for final action along with any comments from the MAC.

(5) The MAC may adopt such amendments to these Bylaws that are, in the committee’s judgment, technical modifications or clarifications. Such modifications may

include reorganization or renumbering, punctuation, spelling or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the Hospital CEO.

(6) Neither the Organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations.

(7) The MAC and the Board may adopt such provisional amendments to these Bylaws that they deem necessary for legal or regulatory compliance. After adoption, the MAC will communicate these provisional amendments to the Bylaws to the Organized Medical Staff for its review.

15.4 REVIEW, REVISION, ADOPTION AND AMENDMENT OF BYLAWS

The Organized Medical Staff shall be responsible for formulating, reviewing (at least biennially), and recommending any Medical Staff Bylaws to the Board as needed. These Bylaws and amendments shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

15.5 METHODS OF ADOPTION AND AMENDMENT TO BYLAWS

(1) Proposed Bylaws and amendments thereto may be voted on at any regular or special meeting of the Medical Staff or submitted to the members of the Active Staff for vote by written or electronic ballot according to such procedures as are approved by the MEC and the Organized Medical Staff.

(2) Amendments so adopted shall be effective when approved by the Board.

(3) The MEC and the Board may adopt such provisional amendments to these Bylaws and regulations that they deem necessary for legal or regulatory compliance. After adoption, the MEC will communicate these provisional amendments to the rules and regulations to the Organized Medical Staff for its review.

(i) If the Organized Medical Staff approves of the provisional amendment, the amendment will stand.

(ii) If the Organized Medical Staff does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Section 12.2(e) or 15.18, as applicable. If a substitute amendment is then proposed, it will follow the usual approval process.

15.6 METHODS OF ADOPTION AND AMENDMENT TO ANY MEDICAL STAFF RULES, REGULATIONS AND POLICIES

(1) The Organized Medical Staff , with the approval of the Board, delegates to the MEC the ability to adopt and amend Medical Staff rules and regulations, policies and procedures without full Organized Medical Staff approval.

(2) If the MEC proposes to adopt a rule, regulation, policy or procedure, or an amendment thereto, it first communicates the proposal to the Organized Medical Staff; when it adopts a policy or an amendment thereto, it communicates this to the Organized Medical Staff.

(3) Any Active Staff member may challenge any rule, regulation, policy, or procedure adopted by the MEC through the following process:

(4) The Board upholds the Medical Staff rules and regulations and policies that have been approved by the Board.

(4) The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, any of these documents may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective when approved by the Board.(5)The MEC may adopt such amendments to these rules, regulations and policies that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the Hospital CEO. Neither the Organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations.

(6) he MEC and the Board may adopt such provisional amendments to these rules and regulations that they deem necessary for legal or regulatory compliance. After adoption, the MEC will communicate these provisional amendments to the rules and regulations to the Organized Medical Staff for its review.

(i) If the Organized Medical Staff approves of the provisional amendment, the amendment will stand.

(ii) If the Organized Medical Staff does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Section 12.2(e). If a substitute amendment is then proposed, it will follow the usual approval process.

15.7 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Managers; or

15.3(b) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Managers. Each Member

of the Medical Staff shall be given a copy of any amendments to these Bylaws in a timely manner.

15.8 JOINT CONFERENCE COMMITTEE

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to a joint conference of an equal number of Medical Staff and Board members for review and recommendation before making its final decision and giving notice of final decision. Individuals participating in a joint conference will be appointed by the Chief of Staff and Chair of the Board. The MEC or the Board may also request the convening of a joint conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

15.9 CONFLICT MANAGEMENT

The conflict management process shall provide for the joint conference committee to:

(a) Meet as early as possible to identify the conflict,

(b) Include additional parties if essential to resolving the conflict;

(c) Gather information about the conflict;

(d) Work with other representatives of both the Medical Staff and the Board as needed to manage and, when possible, resolve the conflict; and

(e) Protect the safety and quality of care.

The committee may utilize the services of a facilitator or mediator for meetings with the approval of the Chair. The Committee shall report to the Medical Executive Committee and Board. If the Committee cannot resolve the conflict in a manner agreeable to all parties, the Board shall proceed with a final decision on the issue that gave rise to the conflict.

ARTICLE XVI

16.1 RULES AND REGULATIONS
(See Attached)

16.2 FAIR HEARING PLAN
(See Attached)

16.3 HOSPITAL POLICY REGARDING IMPAIRED PRACTITIONERS
(See Attached)

16.4 HOSPITAL POLICY REGARDING DISRUPTIVE PRACTITOIINERS CONDUCT
(See Attached)

MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:

MEDICAL STAFF:

By:________________________________ ________________________
Chief of Staff Date

BOARD OF MANAGERS:

By:________________________________ ________________________
Chairperson Date

GRACE MEDICAL CENTER:

By:________________________________ ________________________
Chief Executive Officer Date

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