St. Elizabeth

MEDICAL STAFF BYLAWS

February 2016

INDEX

BYLAWS OF THE MEDICAL STAFF
OF CHI HEALTH ST. ELIZABETH
LINCOLN, NEBRASKA

PREAMBLE

WHEREAS, CHI Health St. Elizabeth ("Hospital") is a nonprofit corporation, organized under the laws of the State of Nebraska, sponsored by Catholic Health Initiatives (“CHI”), a not-for-profit health care system; and

WHEREAS, it is recognized that the Medical Staff of the Hospital is a constituent organization of, and not a separate entity apart from the Hospital, and the Medical Staff and its members act on behalf of the Hospital in peer review, quality assurance, credentialing, utilization review, professional review activities or actions, and other appropriate matters;

WHEREAS, it is recognized that the Medical Staff of the Hospital is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the CHI Health Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the practitioners, physicians and non-physicians, practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. The term "Medical Staff" means the self-governing entity accountable to the governing body that operates under a set of bylaws, rules and regulations, and policies developed and adopted by the voting members of the organized medical staff and approved by the governing body. The organized medical staff is comprised of all physicians holding unlimited licenses and other duly licensed practitioners who are privileged to attend patients in the Hospital.
2. The term "Governing Body" means the Board of Directors of CHI Health.
3. The term "Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.
4. The term "President" means the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital.
5. The term "practitioner" means an appropriately licensed physician with an unlimited license or a non-physician medical care provider who is fully licensed and permitted by law and the Hospital to provide patient care services at the Hospital without direction or supervision and be a member of the Medical Staff.
6. The term "physician" as defined in these Bylaws and Rules and Regulations, includes a doctor of medicine or a doctor of osteopathy, or an oral and maxillofacial surgeon.
7. The term "Hospital administration" means the President or his/her designee.

8. The term "non-physician medical providers" as used in these Bylaws means dentists and podiatrists who are fully licensed and permitted by law to provide patient care services without direction or supervision by a physician.

9. The term “Focused Professional Practice Evaluation” or “FPPE” means a process by which the Medical Staff and/or Hospital evaluates the privilege-specific competence of a practitioner. FPPE is a time-limited period for evaluation of a practitioner’s professional performance.

10. The term “Ongoing Professional Practice Evaluation” or “OPPE” means a process which allows the Hospital and/or the Medical Staff to identify professional practice trends that impact on quality of care, care efficiencies, and patient safety.

11. The term "professional review activity" means an activity of the Hospital with respect to an individual practitioner to determine whether the practitioner may have clinical privileges with respect to, or membership, in the Medical Staff of the Hospital, to determine the scope or conditions of such privileges or membership, or to change or modify such privileges or membership.

12. The term "professional review body" shall mean, as appropriate to the circumstances, the Governing Body, the Credentials Committee, any ad hoc investigation committee, any hearing committee, any appellate review committee, the Hospital administration, the Chief of Staff, any department or service Chair and any other person, committee or entity having authority to make an adverse recommendation with respect to or to propose an action against an applicant for Medical Staff privileges or a Medical Staff member when assisting the Governing Body in professional review activities.

13. The term "professional review action" means an action, recommendation, or decision of the professional review body which is taken or made in the course of professional review activity based on the competence or professional conduct of an individual practitioner, which conduct affects (or could affect) adversely the health or welfare of a patient or patients, and which affects (or may affect) adversely the clinical privileges or staff membership of the practitioner.

14. The term "emergency" means a condition in which serious permanent harm would result to an individual or in which the life of a person is in immediate danger and any delay in administering treatment would add to that danger.

15. The term “immediate supervision” means the supervising physician is readily available or within the hospital.

16. The term “direct supervision” means the supervising physician is physically present while the function or procedure is being performed.

17. The term “general supervision” means that care is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the procedure or patient contact.

18. The term “locum tenens” means a physician who temporarily substitutes for a member of the medical staff or who fulfills an identified need for physician services on a temporary basis.

19. The term “Board Certification” shall mean board certification as determined and approved by the American Board of Medical Specialties, the American Osteopathic Association, American Board of Foot and Ankle, American Board of Podiatric Medicine, American Board of Oral and Maxillofacial Surgery, American Board of General Dentistry or the American Board of Pediatric Dentistry.

20. The term “Admitting Physician” shall mean a member of the Medical Staff who requests the admission or registration for a patient.

21. The term “Attending Physician” shall mean a member of the Medical Staff who has overall responsibility for providing and coordinating the patient’s care and is generally responsible for the discharge summary and final diagnosis.
22. The term “Telemedicine,” for purposes of credentialing, means the use of medical information exchanged from one site to another via electronic communications for the purpose of diagnosing or treating patients.

ARTICLE I : NAME

The name of this organization shall be the CHI Health St. Elizabeth Medical Staff.

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the best possible care;
2. To ensure a high level of professional performance of all practitioners authorized to practice in the Hospital through appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner's performance in the Hospital;
3. To provide an appropriate educational setting which will maintain scientific standards and will lead to continuous advancement in professional knowledge and skill;
4. To develop and adopt rules and regulations establishing a framework for Medical Staff activity and accountability to the Governing Body; and
5. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the President.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

No practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been appointed to the Medical Staff or has been granted temporary privileges in accordance with the provisions of these Bylaws.

Membership on the Medical Staff of CHI Health St. Elizabeth is a privilege which shall be extended only to professionally competent physicians and other practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. No discrimination for membership or for granting or denying clinical privileges shall occur on the basis of race, sex, disability or national origin in Medical Staff appointment or accommodations provided, use of equipment and other facilities, or the assignment of personnel providing services.

Section 2. Qualifications for Membership

a. Only practitioners licensed in the State of Nebraska, who qualify under the rules and regulations of the clinical department to which they will be assigned and who can document their background, experience, training and demonstrated current competence, and their physical and/or mental health status sufficient to perform the privileges requested, adherence to the ethics of their profession, their good reputation, their functional health status, and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given a high quality of medical care, taking into account patient needs, the available Hospital facilities and resources, and utilization standards in effect at the Hospital, shall be qualified for membership on the Medical Staff. No practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that (s)he is duly licensed in this or in any other state or that (s)he is a member of any professional organization, or that (s)he had in the past, or presently has, such privileges at another Hospital. No Practitioner shall be qualified for membership on the Medical Staff unless (s)he has completed a residency approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Council on Podiatric Medical Education, American Dental Association or appropriate equivalent organization or can demonstrate comparable competence by reason of prior training and experience.

b. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that (s)he will strictly adhere to the ethics of his/her profession and the Ethical and Religious Directives of the Catholic Health Association with regard to patients treated at the Hospital.

c. All members of the Medical Staff shall at all times be required to provide and maintain a current certificate of insurance from an insurance company licensed or approved to do business in Nebraska to verify malpractice liability coverage. The amount of coverage required shall be in accordance with the minimum requirement of the Hospital's professional liability insurance carrier as it now exists and as it may hereafter be amended.

d. All members of the Medical Staff shall name an appropriate back-up member of the Medical Staff who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such associate, the Chief of Staff of the Medical Staff or chair of the department concerned, shall have authority to call any member of the Medical Staff with admitting privileges.

e. Each practitioner must reasonably assure timely (which shall mean returning the notification call as soon as possible but not to exceed 30 minutes and being physically available within 30 minutes as requested, based upon what is reasonable for individual patient needs, or having back-up coverage by a member of the Medical Staff who has privileges within an appropriate specialty and is able to provide coverage within 30 minutes—the maximum response time should not exceed 60 minutes unless it is mutually agreeable to both parties), adequate professional care for his patients in the Hospital by being available or having available through his office an eligible alternate with whom prior arrangements have been made. Failure to meet this requirement may result in loss of clinical privileges.

f. All members of the Medical Staff shall participate in continuing education programs pursuant to the requirements of the State of Nebraska.

g. Each practitioner shall have a current, unrestricted license to practice in Nebraska and have not, within the last ten (10) years, had a license to practice revoked or suspended by any state licensing agency.

h. Each practitioner, where applicable in their practice, have a current, unrestricted DEA registration.

i. Each practitioner shall not, within the last ten (10) years, have been convicted of, or entered a plea of guilty or no contest to Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse.

j. Each practitioner shall not, within the last ten (10) years, have been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program.

k. Each practitioner shall not, within the last ten (10) years, have had their Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct.

l. Each practitioner shall not, within the last ten (10) years, have resigned their Medical Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation.

m. Each practitioner shall have not, within the last ten (10) years, been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, violence, or insurance or health care fraud or abuse.

n. Each practitioner shall agree to fulfill all responsibilities regarding emergency call for their specialty.

o. Each practitioner shall agree to make coverage arrangements with another member of the Medical Staff for those times when the individual will be unavailable.

Section 3. Waiver of Qualifications for Membership Criteria:

a. Any individual who does not satisfy one or more of the qualifications for membership criteria outlined above may request that it be waived. The individual requesting a waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

b. A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chairperson, and the best interest of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and/or other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee.

c. The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver.

d. Any recommendation to grant a waiver must include the basis for such.

e. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

f. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

g. An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

Section 4. Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws. The Medical Executive Committee may recommend exceptions to the qualifications for membership and/or privileges, but only the Governing Body can approve such exceptions.

b. Appointments to the staff will be for a period of not more than twenty-four (24) months, unless otherwise approved by the Executive Committee and the Governing Body.

c. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

d. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous, high quality care and supervision of his/her patients, to abide by the Medical Staff Bylaws, Rules and Regulations and the Ethical and Religious Directives of the Catholic Health Association, to accept committee assignments, and to accept consultation assignments. Failure to abide by the CHI Health St. Elizabeth Medical Staff Bylaws, Rules and Regulations and the Ethical and Religious Directives for Catholic Health Care Services may result in suspension from the St. Elizabeth Medical Staff.

Section 5. Organized Health Care Arrangement

Members of the Medical Staff and Allied Health Professionals with privileges participate in the Organized Health Care Arrangement (“OHCA”) with the Hospital for the sole purpose of sharing individually identifiable health information as required in the Medical Staff Rules and Regulations.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Active, Courtesy, Senior, Emeritus, Non-Physician Medical Provider and Leave of Absence categories.

a. The Active Medical Staff. The Active Medical Staff shall consist of physicians who regularly admit patients to or provide medical or surgical care at this Hospital, provide continuous medical or surgical care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, when appropriate, emergency service care and consultation assignments. Podiatrists may admit patients to or provide medical or surgical care at this Hospital but need to designate a member of the Medical Staff who is a M.D. or D.O. for each patient of the Podiatrist. It shall be the responsibility of the Podiatrist to notify the Medical Staff member of the patient’s admission.

b. The Courtesy Medical Staff. The Courtesy Medical Staff shall consist of physicians qualified for Medical Staff membership but who only occasionally admit patients to the Hospital or who only act as consultants. Podiatrists may admit patients to or provide medical or surgical care at this Hospital but need to designate a member of the Medical Staff who is an M.D. or D.O. for each patient of the Podiatrist. It shall be the responsibility of the Podiatrist to notify the Medical Staff member of the patient’s admission. Any Courtesy Medical Staff who admits or provides medical or surgical care for

thirty-six (36) or more patients at the Hospital in a year shall automatically be transferred to Active Staff.

c. The Senior Staff. The Senior Medical Staff shall consist of those physicians who have been members of the Active Medical Staff but have attained the age of 60 years. Any Active Medical Staff members having attained the age of 60 years may be placed on the Senior Staff by applying to the Executive Committee of the Medical Staff for such standing.

   Senior Medical Staff members shall have admitting privileges, shall be appointed to a specific department, shall be eligible to vote, to hold Medical Staff office, to serve on departmental and Medical Staff committees, and to be entitled to the agreed-upon clinical privileges of medical practice, and shall pay dues. They shall not be required to take Emergency Department call. Podiatrists may admit patients to or provide medical or surgical care at this Hospital but need to designate a member of the Medical Staff who is an M.D. or D.O. for each patient of the Podiatrist. It shall be the responsibility of the Podiatrist to notify the Medical Staff member of the patient's admission.

d. The Emeritus Staff. The Emeritus Medical Staff shall consist of physicians whom the Hospital may wish to recognize for their outstanding reputations, their noteworthy contributions to medicine, or their previous long-standing service to the Hospital.

   Emeritus Staff members shall not be eligible to admit patients, to vote, to hold office, or to serve on any Medical Staff committees. They shall not be required to pay dues. Emeritus Staff members shall not be required to apply for reappointment biennially nor provide proof of insurance, once they have left active practice.

e. The Non-Physician Medical Provider Staff. The Non-Physician Medical Provider Staff shall consist of dentists and podiatrists who are fully licensed and permitted by law and the Hospital to provide specified patient care services without the direct supervision of a physician member of the Medical Staff.

   Members of the Non-Physician Medical Provider Staff shall be appointed to a specific department, shall not be eligible to vote, to hold Medical Staff office, or to serve on Medical Staff committees. They shall pay dues, may participate in Emergency Department call, and may have patients admitted to the Hospital under the order of an Active, Senior, or Courtesy member of the Medical Staff.

f. The Community Affiliate Staff. The Community Affiliate Staff will consist of those members who desire to be associated with, but who do not intend to practice at the Hospital. The primary purpose of the Community Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients. Individuals requesting appointment to the Community Affiliate Staff must submit a Community Affiliate Staff application but are not required to satisfy the qualifications pertaining to office location and residency, coverage, and on-call responsibilities.

   Community Affiliate Staff members may visit their hospitalized patients and review their hospital medical records but may not write orders, progress notes or other notations in the medical record; may not admit or attend to patients, exercise any clinical privileges, or actively participate in the provision or management of care to patients at the Hospital; may attend educational activities of the Medical Staff and the Hospital; may not vote, hold office, serve as a department chairperson, division chairperson, or serve as a chairperson of a Medical Staff committee; may be invited to serve on committees (with vote); and may use the Hospital's diagnostic facilities.

The grant of appointment to the Community Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Executive Committee, without any right to a hearing or appeal.

Section 2. Low Volume Provider

When a physician (excluding physicians who have completed a residency or fellowship in the last year) is applying for initial Medical Staff clinical privileges or when applying for reappointment/renewal of clinical privileges, the hospital will require documentation that the physician has admitted or consulted on at least ten (10) patients in the past two (2) years at an accredited (Joint Commission, State, CMS or any other generally accepted accredited agency) hospital.

If the total number of admissions or consults is less than ten (10) patients in the previous two (2) years, in order to admit a patient, the physician will need to ensure that a physician who is not a "Low Volume Provider" is serving as an attending physician during the hospitalization. The physician will continue to be responsible for ED call if applicable. This requirement can be removed once it is documented that the physician has been the Attending Physician or consulted on ten (10) or more patients in the previous two (2) years. In-patient and out-patient admissions are counted towards meeting this requirement.

To remove the low volume provider requirement, the physician should contact the Medical Staff Office.

Section 3. Procedure for Change in Category

In the event a practitioner desires to change his/her Medical Staff category or privileges, the procedure shall be as follows:

a. He/she shall submit a written request for change to the Medical Staff Office including the reasons for such change and the category into which he/she desires to be placed. Upon receipt of such information, the practitioner will be notified if any other documentation is necessary to consider such request.

b. Upon receipt of all necessary information and documentation, such information and documentation shall be submitted to the Department Chair for review and recommendation, if applicable, then to the Credentials Committee for review and recommendation, and thereafter to the Executive Committee for their review and recommendation to the Governing Body. If any of the recommendations to the Executive Committee oppose the requested change, the practitioner shall have the right to appear before the Executive Committee prior to its making its recommendations to informally discuss his/her request.

c. Upon receipt of the recommendation of the Executive Committee, at its next regular meeting after receipt of the recommendation, the Governing Body shall take final action on such request.

d. The Governing Body, through the President, shall give written notice to the practitioner of its final action.

e. The practitioner shall be obligated to fulfill the requirements of his/her current category and/or privileges (including Emergency Department call) until notice from the Governing Body has been received.

Section 4. Leave of Absence

Voluntary Leave of Absence may be granted for good and sufficient reason by the Governing Body on recommendation of the Department Chair, Credentials Committee and the Medical Executive Committee. The request shall include the approximate period of time of the leave, not to exceed two

years, reasons for the leave and arrangements for patient coverage. During the period of the leave, the practitioner shall not exercise clinical privileges at the Hospital, and his/her membership rights and responsibilities shall be inactive. Upon written request of the practitioner, the Leave of Absence may be extended for up to one additional year.

To obtain reinstatement of privileges, the practitioner on Leave of Absence shall submit a written request to the President of the Hospital at least sixty (60) days prior to the expiration of the leave. The request for reinstatement shall include a description of the member's activities during the Leave of Absence and shall include material necessary to properly evaluate the request for reinstatement. If the reinstatement is after the reappointment date, the practitioner will complete the reappointment process as stated in Article V., Section 4. Reinstatement may be granted by the Governing Body on recommendation of the Department Chair, Credentials Committee and the Medical Executive Committee.

If a practitioner on Leave of Absence fails to request reinstatement at least sixty (60) days prior to the expiration of the leave of absence, his/her Medical Staff membership and privileges will be automatically terminated. A practitioner whose membership has been automatically terminated, but wishes to be reinstated, must submit an initial application for appointment and be evaluated as a new applicant.

Section 5. Termination of Medical Staff Appointment

Any practitioner leaving his/her practice for a period of more than three months shall notify the Medical Staff Credentials Committee of the status change. Failure to do so within three months of leaving his or her practice will result in automatic termination of the practitioner's privileges.

ARTICLE V: PROCEDURE FOR APPOINTMENT, REAPPOINTMENT, AND INTERIM REPORTING

Section 1. Application Request

An Application Form must be submitted by each prospective applicant for membership on the Medical Staff. Such form shall include such information as the applicant's board certification, Nebraska licensure, Drug Enforcement Administration Registration status, professional liability insurance status, whether or not the prospective applicant is subject to any actual exclusion from any health care program funded in whole or in part, by the federal government, and the prospective applicant's residence and office proximity to the Hospital to ensure the continuity of patient care. If it is determined that the prospective applicant qualifies for Medical Staff membership based upon the information submitted on the Application Form, the formal approval process will be initiated. A prospective applicant who does not meet the minimum requirements for Medical Staff membership based upon the information submitted on the Application Form shall be notified of that fact. Individuals not meeting the minimum requirements for Medical Staff membership are not entitled to the due process provisions of Article VIII of these Bylaws.

Section 2. Application for Appointment

a. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Staff Executive Committee or Credentials Committee. The application shall require detailed information concerning the applicant's professional qualifications, and shall include the following:

(1) The names of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

(2) The applicant's pledge that (s)he will provide for the continuous care of his/her patients;

(3) Information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily limited, reduced, suspended, revoked, or not renewed and any pending challenges at any other hospital or institution;

(4) Information as to whether his/her membership in a local, state, or national medical society, or his/her license to practice any profession in any jurisdiction, has ever been suspended or terminated; and

(5) Evidence of current licensure within the State of Nebraska.

(6) The applicant's attestation of immunization via completion of the Immunization History form.

The application shall also request information on previously successful or currently pending challenges by the applicant or on behalf of the applicant, to any licensure provision or regulation, whether state, district, or Drug Enforcement Administration, or the voluntary relinquishment of a license. The application shall also request information concerning the applicant's malpractice experience including currently pending professional liability suits, final judgments, or settlements involving the applicant. The application shall include a consent to be executed by the applicant to release information from his/her present and past malpractice insurance carrier. Applicants will have their records, documents, licenses, educational background, and health status investigated.

b. The applicant shall have the burden of producing adequate information for proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. Physician applicants shall be required to provide, on an annual basis, proof of professional liability insurance in the amount of $500,000/$1,000,000 and qualify under the Nebraska Medical Liability Act or insurance coverage in the amount of $1,000,000/$3,000,000 underwritten by an insurance company authorized to sell insurance in Nebraska. Non-Physician Medical Provider applicants shall be required to provide, on an annual basis, proof of professional liability insurance in the amount of $1,000,000/$3,000,000 underwritten by an insurance company authorized to sell insurance in Nebraska, or as approved by the Governing Body.

c. The applicant will be or will become board certified (and will maintain certification) in the specialty in which he/she practices within the time frame specified by the applicant's specialty board or, if not specified, within five years of completion of residency and/or fellowship training. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy—January, 2013. All individuals appointed previously will be governed by the board certification requirements in effect at the time of his/her original appointment.) Any applicant who does not meet this requirement may submit a waiver to the Credentials Committee for consideration. Granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

d. The completed application form shall be submitted to the departmental chairperson. After collecting the references and other materials deemed pertinent, the departmental chairperson shall transmit the application and all supporting materials to the Credentials Committee for evaluation. The application is considered complete when all of the information requested, including a report from the National Practitioner Data Bank, Office of the Inspector General and General Services

Administration, are received, verified, and the Credentials Committee determines that it has sufficient information to act upon the application. All applicants applying for privileges to perform surgery in the Burn Center must be reviewed and approved by the Medical Director of the Burn Center prior to submittal and evaluation by the Credentials Committee.

e. By applying for appointment to the Medical Staff, each applicant thereby signifies the following:

   (1) The applicant's willingness to appear for interviews in regard to his/her application;

   (2) The applicant's authorization of the Hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character, and ethical qualifications;

   (3) The applicant's consent to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the clinical privileges (s)he requests and his/her moral and ethical qualifications for staff membership;

   (4) The applicant's release from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and

   (5) The applicant's release from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information. The terms "Hospital" and "all representatives of the Hospital and its Medical Staff" as used in this section are intended to include the Governing Body and the President and their authorized representatives, and all members of the Medical Staff who have committee or other responsibility for collecting and/or evaluating the applicant's credentials and/or acting upon his/her application. The term "character" is intended to include physical, mental, and emotional stability. The application form should contain a statement that fully informs the applicant of the scope and extent of these authorization, release, and consent provisions, and of the immunity provisions contained in Article XIV of these Bylaws.

f. The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff, as well as the Ethical and Religious Directives of the Catholic Health Association, the CHI Standards of Conduct and a statement that the applicant agrees to be bound by the terms thereof if (s)he is granted membership and/or clinical privileges and without regard to whether the applicant is granted membership and/or clinical privileges. Credentialing shall be performed in accordance with Hospital's Credentialing Procedures Manual. To the extent the provisions in the Credentialing Procedures Manual are inconsistent with these Bylaws, these Bylaws shall control.

g. All members of the Medical Staff shall be required to comply with the Hospital's policy against sexual harassment and its policy on Maintaining Professional Relationships and Impaired Physician. Complete copies of these policies are distributed during physician orientation.

h. A History and Physical examination is to be completed within thirty (30) days prior to admission or twenty-four (24) hours after admission, by a physician, an oral maxillofacial surgeon, approved Podiatrist or Dentist, or other licensed qualified practitioner and to include the chief complaint, details of the present illness, personal and family history, review of systems, complete physician examination, conclusions or impressions and a course of action planned for the patient. An update

to the patient's condition is required if the History and Physical was performed more than twenty-four (24) hours prior to admission. The content of complete and focused History and Physical examinations is delineated in the Rules and Regulations.

i. All members of the Medical Staff shall be responsible for complying with all state and federal laws, rules and regulations, including, but not limited to, COBRA/EMTALA, The Joint Commission, as well as all Hospital rules, regulations, policies and procedures.

j. National Practitioner Data Bank (NPDB).

At initial appointment, medical staff members will be added to the National Practitioner Data Bank Continuous Query service that notifies St. Elizabeth within one business day of the receipt of a new or updated NPDB report on a member of the medical staff. Enrollment in the NPDB Continuous Query service meets the statutory requirements to query as long as practitioners are enrolled in Continuous Query at the time of the mandated 2-year review.

Any report received on a medical staff member will be reviewed by the respective Department Chair, the Chief Medical Officer and the Chair of the Credentials Committee and a determination is made as to whether further review by the Credentials Committee is warranted.

Section 3. Appointment Process

a. After receipt of a completed application for membership, the Credentials Committee shall present a written report of its investigation to the Executive Committee at the Executive Committee's next regularly scheduled meeting. Prior to making this report, the Credentials Committee shall examine the evidence of the applicant's character and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested. Action on an individual's application for clinical privileges shall be withheld until such information is made available and is verified. Every department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the applicant's clinical privileges, and these recommendations shall be made a part of the report. Together with its report, the Credentials Committee shall transmit to the Executive Committee the completed application and a recommendation that the practitioner be either appointed to the Medical Staff, rejected for Medical Staff membership, or that the application be deferred for further consideration.

b. Upon receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the applicant be appointed to the Medical Staff, that (s)he be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may be qualified by probationary conditions relating to such clinical privileges.

c. When the recommendation of the Executive Committee is to defer the application for further consideration, the application must be reconsidered at the next regular meeting of the Executive Committee with a subsequent recommendation for appointment with specified clinical privileges or for rejection of the application for staff membership.

d. When the recommendation of the Executive Committee is favorable to the applicant, the President shall promptly forward it, together with all supporting documentation, to the Governing Body.

e. When the recommendation of the Executive Committee is adverse to the applicant either with respect to staff appointment or clinical privileges, the President shall promptly so notify the applicant by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the applicant has exercised or has been deemed to have waived his/her rights to a hearing as provided in Article VIII of these Bylaws.

f. At its first regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act in the matter. When the action of the Governing Body is favorable, the President will notify the practitioner via regular mail. The practitioner shall be granted clinical privileges for one year, at which time reappointment must be pursued for continued Medical Staff membership. Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Governing Body shall submit the matter to a joint conference committee of the Medical Staff and Governing Body for review and recommendation and may consider the recommendation before making its decision final. If the Governing Body's final decision is adverse to the practitioner with respect to either appointment or clinical privileges, the President shall promptly notify him/her of the adverse decision by certified mail, return receipt requested, and the adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

g. At its first regular meeting after all of the practitioner's rights under Article VIII have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the Medical Staff Executive Committee or a joint conference committee as the case may be, for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of a subsequent recommendation, and new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the practitioner to the Medical Staff or to reject the practitioner for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

Section 4. Focused Professional Practice Evaluation

a. All initial requested clinical privileges, by a current member of the Medical Staff or an initial applicant for appointment to the Medical Staff, shall be subject to a period of FPPE. The Executive Committee or the Department Chair concerned will recommend an individualized evaluation plan pursuant to the policy for Professional Practice Evaluation. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other health care individuals involved in the care of each patient.

b. All practitioners must successfully complete a period of FPPE as part of the recommendation for Medical Staff appointment. The FPPE for newly appointed members of the Medical Staff shall be completed within a twelve (12) month period or within another timeframe established by the Department Chair concerned. The period of FPPE may be extended for up to twelve (12) months if, upon recommendation by the Department Chair concerned, further observation of the practitioner’s performance and clinical competence is necessary. The practitioner shall be informed

of the need for further observation and any conditions of such observation. If, at the end of the extension period, the practitioner has not satisfied the requirements, one of the following two sections will apply:

(1) The practitioner's appointment to the Medical Staff may be voluntarily relinquished if there is insufficient clinical activity for satisfactory evaluation. Upon receipt of notification of voluntary relinquishment due to insufficient clinical activity, the practitioner shall be given an opportunity to request, within thirty (30) days, a meeting with the Executive Committee, the Department Chair concerned, and the President or his or her designee. At that meeting, which is in lieu of a hearing pursuant to Article VIII hereof, the applicant shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient clinical experience for a satisfactory evaluation. At that meeting, none of the parties shall be represented by counsel; minutes shall be kept; the appointee may present evidence of extenuating circumstances and why the minimum requirement should be waived or his or her practice subject to FPPE extended; any party may ask questions of any other party relative to the extension. At the conclusion of the meeting, or if a meeting is not held, the Executive Committee shall make a written report and recommendation to the Governing Body for final action.

(2) If there is a recommendation by the Executive Committee or the Department Chair concerned to terminate the appointee's Medical Staff membership during the FPPE period, to deny advancement from the FPPE, or to reduce clinical privileges due to questions about qualifications, fitness, behavior or clinical competence, the President or his or her designee shall give the appointee notice of the recommendation. In such instances, the practitioner shall be entitled to a hearing pursuant to the Fair Hearing Plan.

c. Each recommendation concerning Medical Staff appointment of a practitioner currently in the FPPE process shall include a written evaluation completed by any assigned proctor or preceptor, if applicable, and the Department Chair concerned, consisting of: overall ethical and professional behavior, clinical competence, and clinical judgment in the treatment of patients; compliance with these Bylaws and the Rules and Regulations of the Medical Staff; use of the Hospital's facilities for patients; capacity to treat patients satisfactorily as indicated in part by the results of the Hospital's quality assessment/risk management activities or other reasonable indicators of continuing qualifications including assessments of the practitioner's capabilities in his/her office practice and at other hospitals; federal and state provider databases and/or other indications of pending or completed actions concerning the status of the applicant as a provider of federally funded or state programs; and compliance with all other applicable minimum requirements for Medical Staff appointment in these Bylaws.

Section 5. Reappointment Process

a. Biennially, the departmental chairpersons shall review all pertinent information available on each practitioner for the purpose of determining their recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the next period and shall transmit their recommendations, in writing, to the Credentials Committee. When nonreappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. Each recommendation by the department chairperson shall be based on the following:

(1) Medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism in the treatment of patients as described by primary source information from affiliations and references;

(2) The results of performance improvement monitoring;

(3) Ethics and conduct;

(4) Physical, mental, and emotional stability;

(5) Compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations, the Ethical and Religious Directives of the Catholic Health Association and the CHI Standards of Conduct;

(6) Cooperation with Hospital personnel;

(7) Use of the Hospital's facilities for the practitioner's patients;

(8) Relations with other practitioners;

(9) Malpractice experience since appointment or last reappointment;

(10) General attitude toward patients, the Hospital, and the public;

(11) Evidence of participation in continuing education programs;

(12) Membership status changes;

(13) Information as to whether the applicant's membership status, clinical privileges, and/or license to practice any profession in any jurisdiction have ever been voluntarily or involuntarily limited, reduced, suspended, revoked, or not renewed and any pending challenges at any other hospital or institution during the current reappointment term as specified in Article V, section 4; and

(14) Reasonable evidence of current health status to determine the applicant's ability to practice in accordance with the standards established by their respective profession as may be requested by the Executive Committee of the Medical Staff.

b. The Credentials Committee shall review recommendations from the department chairperson and may accept, amend or ask for more information on each recommendation. The Credentials Committee will then make written recommendations to the Executive Committee concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner.

c. The Executive Committee shall make written recommendations to the Governing Body, through the President, concerning the reappointment, nonreappoint¬ment, and/or clinical privileges of each practitioner. When the recommendation of the Executive Committee regarding the practitioner's reappointment is favorable, the President shall promptly forward it, together with all supporting documentation, to the Governing Body. Where nonreappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented. Thereafter, the procedure provided in Section 3, subparagraph e, of this Article V relating to recommendations on applications for initial appointment shall be followed.

d. The staff member will certify on the application for reappointment to the Medical Staff that (s)he has read the current Bylaws, Rules and Regulations of the Medical Staff, and that (s)he agrees to abide by all the provisions contained therein.

Section 6. Ongoing Professional Practice Evaluation

The Medical Staff will engage in OPPE in order to identify professional practice trends that impact the quality of care and patient safety. Information from the OPPE will be factored into the decision to maintain existing clinical privileges, to revise existing clinical privileges, or to revoke an existing clinical privilege prior to or at the time of a member’s reappointment. The OPPE shall be undertaken as part of

the Medical Staff's evaluation, measurement, and improvement of a practitioner's current clinical competency, as outlined in the policy for Professional Practice Evaluation. In addition, each practitioner may be subject to an FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE. Decisions to assign a practitioner to a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform a special clinical privilege.

ARTICLE VI : CLINICAL PRIVILEGES

Section 1. Clinical Privileges Restricted

a. Every practitioner practicing at this Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Body, except as provided in sections 2, 3, 4, 5 and 6 of this Article VI.

b. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, functional health status, references, and other relevant information, including an appraisal by the clinical department in which such privileges are sought, and information provided through the National Practitioner Data Bank, Office of the Inspector General and General Services Administration. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges (s)he requests.

c. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals, and review of the records of the Medical Staff which document the evaluation of the practitioner's participation in the delivery of medical care. Applications for additional clinical privileges must be in writing and include the type of clinical privileges desired and the applicant's relevant recent training and/or experience. Such applications will be processed in the same manner as applications for initial appointment.

d. Privileges granted to non-physician medical providers shall be based upon the need for such services and the applicant's training, experience, and demonstrated competence and judgment. The scope and extent of procedures that each non-physician medical provider may perform shall be specifically delineated and granted in the same manner as all other privileges. Surgical procedures performed by non-physician medical providers shall be under the overall supervision of the Surgery Department Chair. All non-physician medical provider patients shall receive the same basic medical appraisal as patients admitted to other medical or surgical services. Non-physician medical providers shall be responsible for that part of the patient's history and physical examination relating to the practitioner's area of practice. A physician member of the Medical Staff shall be responsible for that part of the patient's history and physical examination relating to medicine and for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

e. Clinical privileges for non-physician medical providers will be developed by the Medical Staff department governing the practice area and will be under the authority of the department chair.

f. Every practitioner practicing at this Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be required to immediately report to the Hospital changes in licensure or registration status (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration, changes in professional liability insurance coverage, professional liability judgments against, or settlements by the practitioner, and involuntary termination of Medical Staff membership or limitation, reduction, or loss of clinical privileges at another hospital.

Section 2. Temporary Privileges

a. Temporary privileges will be considered only after the Hospital is in receipt of (1) verification of good standing of the applicant's current state medical license; (2) proof of the applicant's professional liability insurance coverage as required under the Bylaws; (3) report on the applicant from the National Practitioner Data Bank, Office of the Inspector General and General Services Administration; (4) a complete application and all references of the applicant and primary source verification of education and prior medical staff memberships; and (5) no current or previously successful challenges to licensure or registration, not been subject to involuntary termination of medical staff membership at another organization, and not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

b Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, the President may, upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the department chair concerned and of the Chief of Staff, grant temporary admitting and clinical privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the chair of the department to which (s)he is assigned. The President may permit a practitioner to have temporary privileges for a period not to exceed one hundred twenty (120) days.

c. Temporary one-time clinical privileges may be granted by the President or his/her designee, with the concurrence of the Chief of Staff for the care of a specific patient to a practitioner who is not an applicant for medical staff membership after the Hospital is in receipt of (1) verification of the applicant’s current licensure within the state of Nebraska; (2) proof of the applicant’s professional liability insurance coverage as required under the Bylaws; and (3) a report on the applicant from the National Practitioner Data Bank, Office of the Inspector General and General Services Administration; provided that there shall first be obtained such practitioner's signed acknowledgment that (s)he has received and read copies of the Medical Staff's Bylaws, Rules and Regulations and the Ethical and Religious Directives of the Catholic Health Association and that (s)he agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than five (5) patients in any one year by any practitioner, after which time the practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

d. The President may permit a physician serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed ninety (90) days, provided all of his/her insurance, licenses, proof of education, past and current hospital affiliations, references and reports from the National Practitioner Data Bank, Office of the Inspector General and General Services Administration have been obtained, verified and approved by the departmental chair concerned and by the Chief of Staff.

e. Special conditions or requirements of supervision and reporting may be imposed by the departmental chair concerned on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President upon notice of any failure by the practitioner to comply with such conditions.

f. The President may at any time, upon the recommendation of either the Chief of Staff or of the chair of the department concerned, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under his/her care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Article VII, section 2, subparagraph a, of these Bylaws, and the same shall be immediately effective. The appropriate departmental chair or, in his/her absence, the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of a substitute practitioner.

g. Temporary privileges are not to be routinely used for other administrative purposes such as: 1) the physician fails to provide all information necessary to process his/her reappointment in a timely manner and 2) failure of the staff to verify performance data and information in a timely manner.

Section 3. Disaster Privileges

The Chief of Staff or President may grant disaster privileges in accordance to the policy on Credentialing Practitioners in the Event of a Disaster.

Section 4. Consultations

The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient.

Any qualified practitioner with privileges can be called for consultation within his/her area of expertise. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. (S)He will provide written authorization to permit another practitioner to attend or examine his/her patient, except in an emergency.

All consultations shall be done within 24 hours or within a reasonable period of time, depending on patient needs and physician judgment as mutually agreed upon if patient is unstable or emergent.

Consultation is recommended:

a. When the patient is not a good risk for operation or treatment,

b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed,

c. Where there is doubt as to the choice of therapeutic measures to be utilized,

d. In unusually complicated situations where specific skills of other practitioners may be needed,

e. In any instances in which the patient exhibits severe psychiatric symptoms,

f. When the patient has attempted suicide or has taken a chemical overdose, a psychosocial evaluation shall be requested, offered to or arranged for,

g. When requested by the patient or the patient’s family,

h. When required by department rules.

A satisfactory consultation includes examination of the patient and his medical record. A written opinion signed by the consultant must be included in the medical record.

Section 5. Emergency Privileges

In the case of an emergency, any practitioner, whether or not (s)he is a member of the Medical Staff or has been granted delineated clinical privileges to the degree permitted by his/her license, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the physician or non-physician medical provider must request the privileges necessary to continue to treat the patient. In the event the privileges are denied or (s)he does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 6. Telemedicine

Any physician providing patient care and services (including the rendering of a diagnosis or other provisions of clinical treatment) to patients of St. Elizabeth through a telemedicine link with Hospital, must be fully credentialed and granted privileges through one of the following mechanisms:

a. be fully credentialed and granted privileges according to Article V.

OR

b. be granted temporary privileges by accepting the credentialing and privileging decision of the distant site (the site where the practitioner providing the professional services is located) if the distant site is a Joint Commission-accredited organization.

Physicians providing telemedicine services are not eligible to admit patients, to vote, to hold office, or to serve on any Medical Staff committees or be required to take Emergency Department call.

ARTICLE VII: CORRECTIVE ACTION

Section 1. Procedure

a. When the activities or professional conduct of any member of the Medical Staff with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such practitioner may be requested by any officer of the Medical Staff, by the chair of any clinical department, by the chair of any standing committee of the Medical Staff, by the President, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.

b. Whenever the corrective action could result in a recommendation for a reduction or suspension of clinical privileges, the Executive Committee may forward such request to the chair of the department wherein the practitioner has such privileges. Upon receipt of such request, the chair of the department shall immediately appoint an ad hoc committee to investigate the matter.

c. Whenever the corrective action could result in a recommendation for suspension or expulsion from the Medical Staff, the Executive Committee shall appoint an ad hoc investigating committee of the Medical Staff to investigate the matter.

d. Within thirty (30) days after the department's receipt of the request for corrective action or within thirty (30) days after the Executive Committee's appointment of an ad hoc investigating committee of the Medical Staff, the departmental ad hoc investigating committee or the ad hoc investigating committee of the Medical Staff, as the case may be, shall make a report of its investigation to the Executive Committee. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the appropriate ad hoc investigating committee. At the interview, (s)he shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of the interview shall be made by the departmental ad hoc investigating committee or by the ad hoc investigating committee of the Medical Staff and included with its report to the Executive Committee.

e. Within ten (10) working days following the receipt of a report from a departmental ad hoc investigating committee following the department's investigation of a request for corrective action which could involve reduction or suspension of clinical privileges, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on the request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of the appearance shall be made by the Executive Committee.

f. Within ten (10) working days following the receipt of a report from the ad hoc investigating committee of the Medical Staff following its investigation of a request for corrective action which could involve a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

g. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension, or revocation of clinical privileges, or to recommend that the practitioner's staff membership be suspended or revoked.

h. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article VIII of these Bylaws.

i. The Chief of Staff shall promptly notify the President in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the President fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VIII of these Bylaws.

Section 2. Summary Suspension

a. Any one of the following -- the Chief of the Medical Staff, the chair of a clinical department, the President and the Executive Committee of either the Medical Staff or the Governing Body -- shall

each have the authority, to summarily suspend all or any portion of the clinical privileges of a member of the Medical Staff, and the summary suspension shall become effective immediately upon imposition.

b. Termination or nonrenewal of a contract with a physician, officer, or other member of the Medical Staff in an administratively responsible capacity shall result in summary suspension of all of his/her administrative duties. Termination of a contract with a medico administrative officer for grounds unrelated to his/her professional clinical capability or to his/her exercise of clinical privileges, may be accomplished in accordance with the usual personnel policies of the Hospital or the terms of such officer's employment agreement, contract, or other arrangement, if any. To the extent that the grounds for removal include matters relating to competence in performing professional clinical tasks, in supervising the professional activities of practitioners under his/her direction, or in exercising clinical privileges, summary suspension of all or any portion of the practitioner's clinical privileges shall be determined by either the Chief of the Medical Staff, the chair of a clinical department, or the President and the Executive Committee of either the Medical Staff or the Governing Body.

c. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Executive Committee may be convened in accordance with Article VIII of these Bylaws.

d. The Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend the immediate termination of the summary suspension, the affected practitioner shall, in accordance with Article VIII, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision thereon by the Governing Body.

e. Immediately upon the imposition of a summary suspension, the chair of the Executive Committee or responsible departmental chair shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of the suspension. The wishes of the patients shall be considered in the selection of an alternative practitioner.

Section 3. Automatic/Temporary Suspension

a. Failure to provide evidence of appropriate malpractice coverage at any time as required by these Bylaws or action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or placing the practitioner upon probation, shall automatically suspend all of the practitioner's Hospital privileges.

b. A temporary suspension in the form of withdrawal of a practitioner's scheduling or admitting privileges, effective until medical records are completed, may be imposed automatically after receipt of a warning of delinquency for failure to complete medical records in accordance with policies adopted from time to time by the Hospital. In the event of any changes in medical records policies written notice shall be sent to all members of the Medical Staff at least sixty (60) days before implementation.

c. Excluded Provider

Upon notice to the President of an investigation or of a proposed exclusion from any health care program funded in whole or in part by the federal government, the Medical Staff Member is subject

to automatic suspension of all privileges. Upon notice of an actual exclusion from any health care program funded in whole or in part by the federal government, all privileges of the affected practitioner shall be automatically suspended.

Members of the Medical Staff who are excluded from a federally funded health care program shall not have the right to a hearing under Article VIII of these Bylaws regarding the resulting termination of their staff membership and privileges.

However, if the practitioner immediately notifies the President of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws, a meeting with the President and the Chief of Staff, or their designees, to contest the fact of the exclusion and present relevant information shall be granted upon written request to the President. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The President and the Chief of Staff, or their designees, shall determine within ten (10) business days following the meeting and after such follow-up investigation as they deem appropriate, whether the exclusion had in fact occurred, and whether the practitioner's staff membership and privileges shall be immediately terminated. The determination of the President and the Chief of Staff, or their designees, regarding the matter shall be final, and the practitioner shall have no further procedural rights within the Hospital or its Medical Staff. The practitioner shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.

A current practitioner who does not immediately notify the President of the exclusion of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws shall have his/her staff membership and privileges terminated, effective immediately, at such time as the President or his or her designee receives reliable information of the practitioner's exclusion. The practitioner shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.

Whenever a practitioner's membership and privileges are terminated pursuant to this Section, the Chief of Staff and the practitioner's Chair shall take all necessary steps to ensure that any patients currently under the practitioner's care in the Hospital shall immediately be brought under the care of another appropriate practitioner.

No report of any action taken based on a practitioner's exclusion from a health care program funded, in whole or in part, by the federal government shall be made to the state medical board or the National Practitioner Data Bank because the action taken is based on the practitioner's failure to meet or continue to meet a basic qualification of Medical Staff membership.

d. It shall be the duty of the Chief of the Medical Staff to cooperate with the President in enforcing all automatic or temporary suspensions.

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURES

Section 1. Right to Hearing and to Appellate Review

a. When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by the Governing Body, would adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, (s)he shall be entitled to a hearing before an ad hoc hearing committee of the Medical Staff. If the recommendation of the Executive Committee following such a hearing is still adverse to the affected practitioner, (s)he shall

then be entitled to receive a copy of the written recommendations of the ad hoc hearing committee and receive a copy of the written decision of the Executive Committee, including a statement of the basis for the decision and shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter.

b. When any practitioner receives notice of a decision by the Governing Body that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and the decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which (s)he was entitled to a hearing and appellate review, (s)he shall be entitled to a hearing by a committee appointed by the Governing Body, and if the hearing does not result in a favorable recommendation, to an appellate review by the Governing Body, before the Governing Body makes a final decision on the matter.

c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which (s)he is entitled.

Section 2 Request for Hearing

a. The President shall give prompt written notice of the action proposed, the reasons for the action, and a summary of the affected practitioner's rights in the hearing to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested. Such notice shall:

   (1) Advise the applicant of his/her right to a hearing or an appellate review pursuant to Article VIII of these Bylaws;

   (2) Specify that (s)he shall have thirty (30) days following the date of receipt of the notice within which to request a hearing or an appellate review; and

   (3) State that failure to request a hearing or an appellate review within the specified time period shall constitute a waiver of his/her rights to same.

b. The failure of a practitioner to request a hearing or appellate review to which (s)he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to a hearing and to any appellate review to which (s)he might otherwise have been entitled. The failure of a practitioner to request an appellate review to which (s)he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to appellate review on the matter.

c. When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing committee appointed by the Governing Body, the same shall thereupon become and remain effective against the practitioner pending the Governing Body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Body, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Governing Body provided for in section 7 of this Article VIII. In either of these events, the President shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

Section 3. Notice of Hearing

a. Within ten (10) working days after receipt of a request of hearing from a practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, shall schedule and

arrange for a hearing and shall, through the President, notify the practitioner of the time, place, and date so scheduled, by certified mail, return receipt requested. The hearing date shall be within forty five (45) days of receipt of the request, and the practitioner shall be given at least thirty (30) days prior written notice of the date, time, and place of the hearing and a list of witnesses who will testify on behalf of the Executive Committee or Governing Body.

b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that were considered in making the adverse recommendation or decision.

Section 4. Composition of Hearing Committee

a. When a hearing relates to an adverse recommendation of the Executive Committee, the hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Medical Staff appointed by the Chief of Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as chair. No staff member who has actively participated in the consideration of the adverse recommendation or who is in direct economic competition with the practitioner who is the subject of the review shall be appointed a member of the hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.

b. When a hearing relates to an adverse decision of the Governing Body that is contrary to the recommendation of the Executive Committee, the Governing Body shall appoint a hearing committee consisting of no less than three (3) persons to conduct the hearing and shall designate one of the members of this committee as chair. At least one representative from the Medical Staff shall be included on this committee when feasible; however, no member of this committee shall be in direct economic competition with the practitioner who is the subject of the review.

Section 5. Conduct of Hearing

a. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by the use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at the hearing shall be deemed to have waived his/her rights in the same manner as provided in section 2 of this Article VIII and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in section 2.

d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

e. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by an attorney or other individual of his/her choice. Should the practitioner elect to be represented at the hearing by an attorney, (s)he must notify the Chief of Staff and the President at least five (5) working days prior to the scheduled hearing date.

f. The chair of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in a civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing record.

h. The Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one of its members, who may not be by profession an attorney, to represent it at the hearing, to present the facts in support of its adverse decision, and to examine witnesses.

The Executive Committee or the Governing Body, as the case may be, may, at its option, have legal counsel present at the hearing. Should the Executive Committee or the Governing Body elect to be represented at the hearing by an attorney, that body must notify the practitioner at least four (4) working days prior to the scheduled hearing date. It shall be the obligation of such a representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

i. The affected practitioner shall have the following rights: To call and examine witnesses, to introduce written evidence, to cross examine any witness on any matter relevant to the issue of the hearing, to present relevant evidence, to introduce a written statement or evidence, to challenge any witness and to rebut any evidence, to receive a written record of the proceedings, to receive a copy of written recommendations of the hearing officer or panel, including a statement of the basis for the recommendations, to receive a copy of the written decision of the Executive Committee, including a statement of the basis for the decision, and to submit a written statement within ten (10) working days of the close of the hearing. If the practitioner does not testify on his/her own behalf, (s)he may be called and examined as if under cross examination.

j. The hearings provided for in these Bylaws are for the purpose of resolving, on an intraprofessional basis, matters bearing on professional competency and conduct.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

l. Within twenty (20) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation determining whether the adverse recommendation or decision against the affected practitioner was justified by having a factual basis and was not arbitrary,

unreasonable, or capricious and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Governing Body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Governing Body. Following the decision of the Executive Committee or of the Governing Body, as the case may be, the President shall give prompt written notice to the practitioner regarding the decision of the Executive Committee or the Governing Body by certified mail, return receipt requested. Thereafter, the procedures to be followed shall be as provided in section 6 of Article VIII of these Bylaws.

Section 6. Appeal to the Governing Body

a. Within seven (7) days after receipt of notice to an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, (s)he may, by written notice to the Governing Body delivered through the President, request an appellate review by the Governing Body. The practitioner may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

b. If the appellate review is not requested within seven (7) days after receipt of notice of the adverse recommendation or decision, the affected practitioner shall be deemed to have waived his/her right to the appellate review, and to have accepted the adverse recommendation or decision, and the adverse recommendation or decision shall become effective immediately as provided in section 2 of this Article VIII.

c. Within five (5) working days after receipt of a request for appellate review, the Governing Body shall schedule a date for the review, including a time and place for oral argument if it has been requested, and shall, through the President, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the date scheduled. The date of the appellate review shall not be less than fifteen (15) days, nor more than thirty (30) days, from the date of receipt of the request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, the review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than twenty (20) days from the date of receipt of the request.

d. The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than five (5) members.

e. The affected practitioner shall have access to the report, record, and transcription, if any, of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. (S)he shall submit a written statement in his/her own behalf in which those factual and procedural matters with which (s)he disagrees and his/her reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. The written statement shall be submitted to the Governing Body through the President by certified mail, return receipt requested, at least five (5) working days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the chair of the hearing committee appointed by the Governing Body, whichever is appropriate, and if submitted, the President shall provide a copy thereof to the practitioner at least five (5) working days prior to the date of the appellate review by certified mail, return receipt requested.

f. The Governing Body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e, of this section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified by having a factual basis and was not arbitrary, unreasonable, or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at the appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Executive Committee or the Governing Body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

g. New or additional matters not raised during the original hearing or in the hearing committee report, not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether the new matters shall be accepted and considered.

h. If the appellate review is conducted by the Governing Body, it may affirm, modify, or reverse its prior decision, or, in its discretion, refer the matter back to the appropriate hearing committee for its review and recommendation within ten (10) working days after the referral. The referral may include a request that the hearing committee arrange for a further hearing to resolve specified disputed issues.

i. If the appellate review is conducted by a committee of the Governing Body, the committee shall, within ten (10) working days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify, or reverse its prior decision, or refer the matter back to the appropriate hearing committee for further review and recommendation within ten (10) working days after referral. The referral may include a request that the hearing committee arrange for a further hearing to resolve disputed issues. Within seven (7) working days after receipt of a recommendation after referral, the committee of the Governing Body shall make its recommendation to the Governing Body as above provided.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 7. Final Decision by Governing Body

a. Within fourteen (14) days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice of its final decision to the Executive Committee and, through the President, to the affected practitioner by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final. The Governing Body's final decision shall not be subject to further hearing or appellate review. However, if the decision is contrary to the Executive Committee's last recommendation, the Governing Body shall refer the matter to a joint committee consisting of the President, two (2) members of the Governing Body appointed by the chair of the Governing Body, and two (2) members of the Medical Staff appointed by the Chief of Staff for further review and recommendation within seven (7) working days after the matter's referral to the joint committee, and shall include in the notice to the practitioner a statement that a

final decision will not be made until the joint committee's recommendation has been received. At its next meeting after receipt of the joint committee's recommendation, the Governing Body shall make its final decision with the same effect and notice as first provided above in this section 7.

b. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee of the Medical Staff, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

ARTICLE IX: OFFICERS

Section 1. Officers of the Medical Staff

a. The officers of the Medical Staff shall consist of the following:

   (1) The Chief of Staff,

   (2) The Vice Chief of Staff, and

   (3) The Secretary Treasurer.

Section 2. Qualifications of Officers

a. Officers shall be a member of the Active or Senior Medical Staff qualified by training, experience and demonstrated ability for the position. Physicians appointed or elected as Officers are required to:

   (1) Be board certified in an appropriate specialty.

   (2) Be members of the Active Medical Staff for at least two years; and

   (3) Be reappointed to the Medical Staff at least one time to assure that the quality and extent of their services are evaluated for clinical competency.

Section 3. Election of Officers

a. Officers shall be elected by a majority of the votes cast and the results shall be announced at the annual meeting of the Medical Staff. Only members of the Active and Senior Medical Staff shall be eligible to vote.

b. The nominating committee shall consist of three past Chiefs of Staff appointed by the Chief of Staff. This committee shall offer one or more nominations for each office.

c. Nominations may also be made by petition signed by at least ten (10) members of the Active and Senior Staff and filed with the Secretary-Treasurer of the Medical Staff at least ten (10) days prior to the annual meeting.

Section 4. Term of Office

All officers shall serve a two year term from their election date or until a successor is elected. Officers shall take office on the first day following the Annual Medical Staff meeting.

Section 5. Removal of Officers

A Medical Staff Officer may be removed from his/her duties for inappropriate performance or nonperformance of responsibilities by a majority vote of the Active Medical Staff; under such

circumstances a replacement will be elected at that time. Grounds for removal of a Medical Staff Officer or Departmental Chair shall include, but not be limited to:

a. Failure to perform the duties of the position held in a timely and appropriate manner,

b. Failure to continuously satisfy the qualifications for the position,

c. Having an automatic or summary suspension imposed or corrective action,

d. Conduct or statements inimical or damaging to the best interests of the staff or hospital or to their goals, programs or public image,

e. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.

Any dismissal or removal from office shall in no way affect the officer's clinical privileges and he/she is afforded no rights on account of such removal under the Hearing and Appellate Review Procedures.

Section 6. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.

Section 7. Duties of Officers

a. Chief of Staff: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff in all matters of mutual concern within the Hospital and shall perform the following functions:

   (1) Act in coordination and cooperation with the President in all matters of mutual concern within the Hospital;

   (2) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

   (3) Serve as chair of the Medical Staff Executive Committee;

   (4) Serve as ex officio member of all other Medical Staff committees without vote;

   (5) Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for 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;

   (6) Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees except the Executive Committee;

   (7) Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the President;

   (8) Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

   (9) Be the spokesman for the Medical Staff in its external professional and public relations.

b. Vice Chief of Staff: In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. (S)he shall be a member of the Executive Committee of the Medical Staff and shall serve as Chair of the Credentials Committee. (S)he shall automatically succeed the Chief of Staff when the latter is unable to complete his/her term for any

reason. At the conclusion of his/her two year term, (s)he shall automatically assume the office of Chief of Staff.

c. Secretary Treasurer: (S)he shall be a member of the Executive Committee of the Medical Staff. The secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, oversee the safeguarding of staff funds, the administration of staff expenditures, the collection of dues and assure that an accurate account of staff funds is kept; pay out money when authorized by the Executive Committee and perform any other duties as ordinarily pertain to his/her office.

ARTICLE X : CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments and Services

Each department shall be organized as a separate part of the Medical Staff and shall have a chair responsible for the supervision of the clinical work within the department. Clinical departments shall be:

a. Anesthesia
b. Emergency Medicine
c. Family Medicine
d. Medicine
e. Obstetrics & Gynecology
f. Pathology
g. Pediatrics
h. Radiology
i. Surgery

Because of the number, diagnosis of patients, specialized problems unique to the department, delineation of privileges, and other factors, each department may organize itself into sections.

The Department of Surgery shall organize itself as follows:

a. Ophthalmology-Otorhinolaryngology
b. Orthopedics
c. Urology
d. General Surgery
e. Neurosurgery
f. Plastic
g. Dentistry

Section 2. Qualifications, Selection, and Tenure of Department Chairs

a. Each chair shall be a member of the Active or Senior Medical Staff qualified by training, experience and demonstrated ability for the position. Physicians appointed or elected as Department Chairs are required to:

(1) Be board certified in an appropriate specialty.

(2) Be members of the Active Medical Staff for at least two years; and

(3) Be reappointed to the Medical Staff at least one time to assure that the quality and extent of their services are evaluated for clinical competency.

b. Each chair shall be elected for a two year term and shall be eligible for reelection to one (1) two year term, subject to approval of the Governing Body.

c. Removal of a chair during his/her term of office may be initiated by a majority vote of the Active and Senior Medical Staff members of the department.

Section 3. Functions of Department Chairs

Each chair shall:

a. Be accountable for all professional and administrative activities within his/her department;

b. Be a member of the Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own department to assure quality patient care;

c. Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report regularly thereon to the Executive Committee;

d. Be responsible for assuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care provided within the department and the clinical performance of all individuals having clinical privileges in the department;

e. Be responsible for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her department;

f. Be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff;

g. Transmit to the Executive Committee his/her department's recommendations concerning staff classification, reappointment, and delineation of clinical privileges for all practitioners in his/her department;

h. Assist in the teaching, education, and research program in his/her department;

i. Participate in every phase of administration of his/her department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, type and scope of services, supplies, special regulations, standing orders, techniques, and space and resource allocations;

j. Assist in the preparation of annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the President, or the Governing Body; and

k. Be responsible for recommending to the Medical Staff the criteria for clinical privileges in the department.

Section 4. Functions of the Departments

a. Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and the Governing Body, for the granting of clinical privileges and for the holding of office in the department.

b. Each clinical department shall establish a medical care evaluation procedure and be responsible for conducting a primary retrospective or prospective review of completed records of discharged patients and other pertinent departmental sources of medical information relating to patient care for the purposes of selecting cases for presentation at the regular departmental meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure optimal patient care. Such reviews shall be conducted regularly and should include a consideration of selected deaths, unimproved patients, patients with infection, complications, errors in diagnosis and treatment, and other instances believed to be important, such as patients currently in the Hospital with unsolved clinical problems.

c. Each department should meet on at least a quarterly basis. Review and analysis on a peer group basis of the quality and appropriateness of the clinical work of each department shall be performed on at least a quarterly basis. Each department shall document meeting activities through minutes that assure effective communication among the Medical Staff, the Hospital administration, and the Governing Body. Each surgical division of the Medical Staff shall also conduct a comprehensive tissue review for justification of all surgery performed whether tissue was removed or not, and for the acceptability of the procedure chosen. Specific consideration shall be given to the agreement or disagreement of the preoperative and pathological diagnosis.

Section 5. Assignment to Departments

a. The Executive Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

b. Family practitioners shall have clinical privileges in one or more departments in accordance with their education, training, experience, and demonstrated competence. They shall be subject to all of the rules of such departments and to the jurisdiction of each departmental chair and/or service chief involved, including the Department of Family Medicine.

Section 6. Assignment to Sections

The departmental chair may, after due consideration of education, training, experience, and demonstrated competence, assign approved practitioners to sections within the department.

ARTICLE XI: COMMITTEES

Section 1. Standing and Special Committees

Standing committees shall include the following committees: Executive, Credentials, Nominating, Medical Records, Community Transfusion, and Cancer. Special committees will include, but are not limited to, Pharmacy, Bylaws, CME, Perinatal, Infection Control, Critical Care, Performance Improvement Council and Physician Excellence Committee.

Section 2. Executive Committee

a. Composition: The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the chairs of each clinical department and the Hospitalist Medical Director. The Chief of Staff shall preside as chair of the Executive Committee. The President and members of his/her administrative team will be ex officio members without vote, and will sit with the committee at all times except when it is in executive session.

b. Duties of the Executive Committee shall be:

(1) To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(2) To coordinate the activities and general policies of the various departments;

(3) To receive and act upon reports and recommendations from Medical Staff committees, clinical departments/services, and assigned ad hoc committees;

(4) To approve and implement the policies of the Medical Staff not otherwise the responsibility of the departments;

(5) To provide liaison between the Medical Staff and the President and the Governing Body;

(6) To recommend action to the President on matters of a medico-administrative nature;

(7) To make recommendations on Hospital management matters (i.e., long range planning) to the Governing Body through the President;

(8) To fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital;

(9) To ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;

(10) To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agents;

(11) On behalf of the Governing Body, to review the credentials of all applicants and to make recommendations for staff membership, assignments to clinical departments and delineation of clinical privileges, in accordance with Article V and Article VI of these Bylaws;

(12) On behalf of the Governing Body, to review periodically all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;

(13) On behalf of the Governing body, to take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted; and

(14) To report at each general staff meeting.

c. Meetings: The Executive Committee shall meet monthly and shall maintain a permanent record of its proceedings and actions.

Section 3. Credentials Committee

a. Composition: The Credentials Committee shall consist of at least five (5) members of the Active and Senior Medical Staff, to be appointed by the Chief of Staff. Members are selected on a basis that will

ensure representation of the major clinical specialties, the Hospital based specialties, and the Medical Staff at large. The Vice Chief of Staff shall serve as chair.

b. Duties: The duties of the Credentials Committee shall be:

(1) On behalf of the Governing Body, to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles V and VI of these Bylaws;

(2) To report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which the applicant requests privileges;

(3) To investigate any breach of ethics that is reported to it;

(4) To review reports that are referred to it by the Executive, Medical Record, and Performance Improvement Council and by the Chief of Staff;

c. Meetings: The Credentials Committee shall establish a procedure that will permit it to fulfill its duties as outlined in these Bylaws, shall meet as often as necessary, and shall keep a permanent record of its proceedings and actions.

Section 4. Nominating Committee

The Nominating Committee shall consist of three (3) past Chiefs of Staff appointed by the Chief of Staff. This committee shall offer one or more nominations for each Medical Staff office.

Section 5. Medical Records Committee

a. Composition: The Medical Records Committee shall consist of at least six (6) representatives from the Medical Staff and at least one each from nursing, health information management, and Hospital administration. The Director of Health Information Management shall act as secretary of the committee.

b. Duties: The Medical Records Committee shall on behalf of the Governing Body:

(1) Be responsible for assuring that all medical records meet the highest standards of patient care usefulness and historical validity. The Medical Staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events. The committee shall conduct a review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of physician responsibility for patient care. The committee shall maintain written reports of conclusions, recommendations, actions taken, and the results thereof.

(2) Provide oversight of the medical record function, inclusive of a representative sampling of open and closed patient records;

(3) Review and approve all new and significantly revised forms used for documentation in the medical record;

(4) Review the timeliness of medical record completion by Medical Staff members to assure completion within the time frame established in the Medical Staff Rules and Regulations;

(5) Delegate the transfusion review function to the Lincoln Community Transfusion Committee, which will forward its findings and actions to the Performance Improvement Council for action.

c. Meetings: The Medical Records Committee shall meet not less than quarterly, shall maintain a permanent record of its findings, proceedings, and actions and shall make a report thereof to the Executive Committee.

Section 6. Pharmacy Committee

a. Composition: Membership shall consist of at least four (4) representatives of the Medical Staff and one each from the pharmaceutical service, the nursing service, and hospital management. The Hospital pharmacist shall be a member of and act as secretary for the committee.

b. This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital, including antibiotic utilization review, to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

(1) Serve as an advisory group to the Hospital Medical Staff and the pharmacist on matters pertaining to the choice of available drugs;

(2) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(3) Develop and review periodically a formulary or drug list for use in the Hospital;

(4) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(5) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(6) Establish standards for the use and control of antibiotics, investigational drugs, and other important drugs, and for research in the use of recognized drugs;

(7) Review all significant untoward drug reactions; and

(8) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken.

c. Meeting: The Pharmacy Committee shall meet at least quarterly but as often as necessary to conduct business, and send quarterly reports to the Executive Committee regarding its activities. Minutes of each meeting shall be retained for permanent file.

Section 7. Infection Control Committee

a. Composition: The Infection Control Committee shall consist of at least one representative from each of the clinical departments and Hospital management.

b. Duties: The Infection Control Committee shall on behalf of the Governing Body be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities including, without limitation, the following:

(1) Operating rooms, delivery rooms, recovery rooms, special care units;

(2) Sterilization procedures by heat, chemicals or otherwise;

(3) Isolation procedures;

(4) Prevention of cross infection by anesthesia apparatus or inhalation therapy equipment;

(5) Testing of Hospital personnel for carrier status;

(6) Disposal of infectious material; and

(7) Other situations as requested by the Executive Committee.

c. Meetings: The Infection Control Committee shall meet not less than every two months, shall maintain a record of its proceedings and activities, and shall report at least quarterly thereon to the Executive Committee.

Section 8. Cancer Committee

a. Composition: The Cancer Committee membership is multidisciplinary, representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services. This shall include but not be limited to the following representatives.

(1) At least one (1) physician member from the required specialties: Diagnostic Radiology, Pathology, General Surgery, Medical Oncology, Radiation Oncology, and Cancer Liaison Physician.

(2) At least one (1) non-physician member from: Cancer program

administration, Oncology nursing, Social Services/Case Management, Cancer Registry (CTR), Pain Control/Palliative Care Specialist, Performance Improvement, Clinical Research, Genetic Professional/Counselor, Psychosocial Services, and Community Outreach.

(3) Additional physician or non physician cancer committee members will be added as required by the American College of Surgeons Commission on Cancer based upon the category of Cancer Program.

(4) Other members as determined by Cancer Committee.

(5) The Cancer Committee chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the Cancer Committee and may fulfill the role of one of the required physician specialties.

b. Duties: The Cancer Committee shall provide leadership for the Hospital's clinical, educational, programmatic, and community outreach endeavors related to cancer care. The responsibilities of the Committee are located in the Cancer Committee Organizational Charter.

c. Meetings: The Cancer Committee shall meet at least quarterly and the Cancer Conferences shall be held weekly the schedule to be determined by the committee. A permanent record shall be maintained for all Cancer Committee meetings and Cancer Conferences. In order for the hospital to maintain accreditation, the Commission on Cancer Program requires each member to attend at least 50% of the Cancer Committee meetings held during any given year.

Section 9. Performance Improvement Council

a. Composition: The Performance Improvement Council shall consist of three Directors, nine Active medical staff members, at least one each from each department selected by the department's chair; a Patient Care Coordinator selected by the Vice President of Nursing; a Clinical Nurse Specialist; the Physician Co-Leader; a Quality Specialist; an Administrative Representative; a Safety Officer and the Risk Management Coordinator.

b. Responsibilities: The Performance Improvement Council shall include but not be limited to:

1 Continuously improve important processes and outcomes related to patient care and organizational functions.

2 Monitor and improve Dimensions of Performance:

- Taking the appropriate action
- Efficacy
- Appropriateness
- Performing the appropriate action well:

  Availability

  Timeliness

  Effectiveness

  Continuity

  Safety

  Efficiency

  Respect and Caring

3 Responsible for coordinating a systematic approach for improving health outcomes by coordinating performance improvement activities for the Hospital.

4 Evaluate, prioritize, commission and monitor cross-functional Performance Improvement Teams.

- Clinical Pathway Development
- Performance Improvement Projects
- Other

5 Promote organization-wide collaborative efforts for performance improvement.

- Policies and procedures
- Communication

6 Ensure that new services develop performance criteria for their processes.

7 Establish, monitor and evaluate performance measures approved by the Council.

- Hospital quality profile.
- Re-engineering outcomes.

8 Monitor and evaluate core processes and standing committee actions.

- Patient satisfaction.
- Patient safety.
- Procedure monitoring.
- Blood utilization.
- Risk management.
- Clinical pathway outcomes.
- Medication administration and errors.

9 Serve in an advisory capacity to:

- Medical staff.
- Associates.
- Continuum of care issues.
- External agencies (nursing homes, physician offices, transportation, etc.)

10 Benchmark quality practices locally, regionally and nationally.

11 Serve as the utilization review committee for the Hospital and shallconduct utilization review as requested and provide recommendations.

c. Meetings: The Performance Improvement Council shall meet monthly with the time and day determined by the Physician Leader in conjunction with other members of the Council.

Section 10. Surgery Committee

a. Composition: The Surgery Committee shall consist of the Chairmen of Surgery, OB/GYN, Anesthesia, Pathology, and the Surgery Section Chairs, as well as the Director of Performance Improvement, representatives from nursing service and Hospital administration and all members of the Department of Surgery.

b. Responsibilities: The Surgery Committee shall meet to review the functions within the surgical area and to recommend additions or changes in policy or rules when indicated.

c. Meetings: The Surgery Committee shall meet at least quarterly with the time and day determined by the Chair in conjunction with other members of the Committee, shall maintain a record of its proceedings and activities and shall report thereon to the Executive Committee.

Section 11: Physician Excellence Committee

a. Composition: The Physician Excellence Committee shall consist of seven (7) to eleven (11) members with a balanced representation of the main specialty areas of the Hospital. The Vice Chief of Staff shall also serve as a committee member.

b. Duties: The Physician Excellence Committee shall include but not be limited to reviewing the medical and hospital care provided in Hospital and the use of Hospital facilities and assisting individual physicians and surgeons as well as Allied Health Practitioners practicing in Hospital and the administrators and nurses employed in the operation of Hospital in maintaining and providing a

high standard of medical and hospital care and promoting the most efficient use of Hospital facilities.

c. Meetings: The Physician Excellence Committee shall meet monthly.

Section 12. Committees for Special Services and/or Functions

As the Hospital's interests and services expand, the Medical Staff shall develop appropriate committees to direct or monitor, review and analyze these services on a regular basis. These include, but are not limited to, the following committees:

a. Critical Care Committee. The Critical Care Committee serves as the coordinating body for the establishment of critical care protocols, the development of policies and procedures used, and, on behalf of the Governing Body, the evaluation of care delivered in the critical care units of the emergency department, neonatal intensive care, burn center, and the intensive care, coronary care, and progressive care units as well as respiratory therapy. The committee is also responsible for the Hospital's code review function.

b. Perinatal Committee. The Perinatal Committee serves as the coordinating body for the establishment of perinatal protocols, the development of policies and procedures used, and, on behalf of the Governing Body, the evaluation of care delivered in labor and delivery, neonatal intensive care, and the post partum unit.

c. Medical Staff Bylaws. The Medical Staff Bylaws Committee shall be responsible for making recommendations relating to revisions to and updating of the Bylaws, Rules and Regulations of the Medical Staff.

d. Community Transfusion Committee. The Community Transfusion Committee shall establish criteria and review the use of blood and blood components, review all transfusions administered at the Hospital, maintain Hospital usage statistics, evaluate all transfusion reactions, report findings to the Performance Improvement Council, provide needed educational materials, and provide medical advisory functions for the Community Blood Bank.

e. Interprofessional Continuing Education Committee. The Interprofessional Continuing Education Committee shall be responsible for overseeing the continuing medical education needs of the medial staff. The committee will assist with the educational and programming needs of staff members to continually improve educational resources and opportunities to enhance patient care. Composition of this committee shall be determined by the complexity of the services provided.

ARTICLE XII: MEDICAL STAFF MEETINGS

Section 1. Annual Meeting

The Medical Staff shall hold an annual meeting in January. The agenda of the annual Medical Staff meeting shall include communications, report review, issue discussion, and voting necessary to conduct the business and affairs of the Medical Staff. Notice regarding the time and place of the annual meeting of the Medical Staff shall be delivered to each member of the Medical Staff at least two (2) weeks in advance. The written or printed notice stating the place, day, and hour of the annual meeting of the Medical Staff may be delivered, either personally or by mail to each member of the Active Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to the staff member at his/her address as it appears on the records of the Hospital.

Section 2. Special Meetings

a. The Chief of Staff or the Executive Committee may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty-one (21) days after receipt by him/her of a written request for the same signed by not less than 1/4 of the Active Medical Staff and stating the purpose for the meeting. The Executive Committee shall designate the time and place of any special meeting.

b. A written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail to each member of the Active Staff not less than seven (7) nor more than twenty one (21) days before the date of the meeting, by or at the direction of the Chief of Staff or his/her designee. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to members of staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Quorum and Voting

Unless otherwise provided, the number of Active Medical Staff members in attendance at a properly called meeting of the Medical Staff shall constitute a quorum for all actions. The action of a majority of those present and voting shall constitute the action of the Medical Staff unless otherwise provided.

Section 4. Attendance Requirements

Each member of the Active Medical Staff is encouraged to attend and participate in Medical Staff meetings.

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Meetings

Committees may, by resolution, schedule regular meetings without notice other than such resolution. Departments shall hold meetings in accordance with the respective department's rule and regulations to review and evaluate the clinical work of practitioners with privileges in the department. At the regular department meetings, emphasis must be placed on morbidity and mortality analysis with detailed consideration of selected deaths, unimproved hospitalized patients, infections, complications, errors in diagnosis, results of treatment, and analytical reports relative to patient care within the Hospital. Scientific subjects related to improved diagnosis or therapeutic approach may also be utilized.

Section 2. Special Meetings

A special meeting of any committee or department may be called by or at the request of the chair thereof, by the Chief of Staff, or by 1/3, but not less than two (2), of the group's members.

Section 3. Notice of Meetings

The person or persons calling the meeting shall give written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution to each member of the committee or department not less than seven (7) days before the time of the meeting. The

written or oral notice shall be given either personally or by United States mail. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail postage prepaid and addressed to the member at his/her address as it appears on the records of the Hospital. The attendance of a member at a meeting shall constitute a waiver of notice of the meeting.

Section 4. Quorum and Voting

a. Each department may establish in its rules and regulations a number and/or percentage of members necessary to constitute a quorum at any meeting.

b. Unless otherwise provided, the number of Active Medical Staff members in attendance at a properly called meeting of the Medical Staff shall constitute a quorum for all actions. The action of a majority of those present and voting shall constitute the action of the Medical Staff unless otherwise provided.

Section 5. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing that sets forth the action so taken and is signed by each member entitled to vote.

Section 6. Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except that ex officio members may not vote, nor shall they be counted in determining the existence of a quorum.

Section 7. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and of the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval. After approval is obtained, the minutes shall be forwarded to the

Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting. The original minutes of all Medical Staff department and committee meetings shall be maintained in the office of the President.

Section 8. Attendance Requirements

a. Each member of the Active Medical Staff is expected to attend and participate in departmental and committee meetings of which (s)he may be a member.

b. Failure by a practitioner to attend any meeting with respect to which (s)he was given notice that attendance was mandatory, unless excused by the Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or a portion of the practitioner's clinical privileges as the Executive Committee may direct, and the suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the practitioner makes a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the chair of his/her department, or by the Executive Committee if the chair is the practitioner involved, until not later than the next regular departmental meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE XIV: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this Hospital.

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

Second, the privilege shall extend to members of the Hospital's Medical Staff, its Governing Body, its other practitioners, its President and his/her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

Third, there shall be, to the fullest extent permitted by law, absolute immunity from civil liability to the Hospital's Medical Staff and its Governing Body, its other practitioners, staff and employees, its President, his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon same arising from any act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, the immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities including, but not limited to:

a. Applications for appointment or clinical privileges;

b. Periodic reappraisals for reappointment or clinical privileges;

c. Corrective action, including summary suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews;

g. Other Hospital, departmental, service, or committee activities related to quality patient care and interprofessional conduct;

h. Professional review actions or activities; and

i. Quality assessment activities and peer review activities.

Fifth, the acts, communications, reports, recommendations, and disclosures referred to in this Article XIV may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter directly or indirectly having an effect on patient care.

Sixth, in furtherance of the foregoing, each practitioner shall, upon request of the President, execute a release in accordance with the tenor and import of this Article XIV, in favor of the individuals and organizations specified above, subject to requirements, including those of good faith, absence of malice, and exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State or under any other law.

Seventh, the consents, authorizations, releases, rights, privileges, and immunities provided by section 1 of Article V of these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with the applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

ARTICLE XV: RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The Rules and Regulations shall be a part of these Bylaws and may be amended by either of the following methods:

1. These Rules and Regulations may be amended at any regular or special meeting of the Medical Staff, provided, however, that a proposed amendment shall have been first reviewed by the Bylaws Committee and submitted to the Executive Committee for their recommendation and transmittal to the Medical Staff, and provided that the proposed amendment shall have been submitted in writing to the Medical Staff at least fifteen (15) days prior to the scheduled regular or special meeting. To be adopted, an amendment shall require a quorum, as defined in Article XII, section 3. Amendments so made shall be effective when approved by the Governing Body.
2. In the event an urgent amendment to the Rules and Regulations is necessary to comply with laws or regulations, the Executive Committee may provisionally adopt and the Governing Body may provisionally approve an urgent amendment without prior notification to the Medical Staff. The urgent amendment will be distributed in writing to the Medical Staff for a retrospective review of and opportunity for comment on the provisional amendment. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment stands. If there is a conflict over the provisional amendment, every reasonable attempt should be made to address issues of conflict; through the chain of command. When this is not possible or successful, the CEO/designee, Chief of the Medical Staff, and Chairperson of the Governing body shall collaborate to take action to address the conflict (see Leadership Conflict Management Policy). If necessary, a revised amendment is then submitted to the Governing Body for action.

It is expected that departmental rules and regulations (and amendments thereto) will be adopted by each department and will be submitted for approval to the Executive Committee and to the Governing Body.

ARTICLE XVI: BYLAWS AMENDMENTS

These Bylaws may be amended at any regular or special meeting of the Medical Staff, provided, however, that a proposed amendment shall have been first reviewed by the Bylaws Committee and submitted to the Executive Committee for their recommendation and transmittal to the Medical Staff, and provided that the proposed amendment shall have been submitted in writing to the Medical Staff at least fifteen (15) days prior to the scheduled regular or special meeting. To be adopted, an amendment shall require a quorum, as defined in Article XII, section 3. Amendments so made shall be effective when approved by the Governing Body.

ARTICLE XVII: ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Governing Body of the Hospital. Neither body may unilaterally amend the Medical Staff Bylaws.

ARTICLE XVIII: REVIEW

These Bylaws shall be reviewed at least every two years by the Executive Committee of the Medical Staff, and the results of each review shall be reported to the members of the Medical Staff.

ADOPTED by the Medical Executive Committee on February 3, 2016.

APPROVED by the Governing Body on February 18, 2016.