



MEDICAL STAFF BYLAWS

Rules and Regulations

Revised May, 2006

MEDICAL STAFF BYLAWS

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**THE MEDICAL CENTER
MEDICAL STAFF BYLAWS**

PREAMBLE

Recognizing that the Medical Staff is responsible for providing oversight for patient safety and, the quality of care, treatment and services provided by practitioners with privileges in the hospital and must accept and assume the responsibility, and recognizing that the Medical Staff is subject to the ultimate authority of the hospital Board of Directors, the physicians practicing in The Medical Center hereby organize themselves in conformity with the Bylaws set forth herein.

ARTICLE I DEFINITIONS

The following definitions shall apply to terms used in these bylaws:

- (1) “Board” means the Board of Directors of The Medical Center, who has the overall responsibility for the conduct of the hospital;
 - (2) “Medical Executive Committee” means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board”;
 - (3) “Hospital” means The Medical Center, 250 Park Street, Bowling Green, KY 42101 or 456 Burnley Road, Scottsville, KY 42164.
 - (4) “Medical Staff” means all physicians and dentists who are given privileges to treat patients in the hospital;
 - (5) “Physicians” shall be interpreted to include both doctors of medicine and doctors of osteopathy;
 - (6) “Chief Executive Officer” means the individual appointed by the Board to act on its behalf in the overall management of the hospital. Reference to the Chief Executive Officer shall also mean the Chief Executive Officer’s designee.
 - (7) “Clinical privileges” means authorization to provide specific care and treatment services in the hospital, reasonable access to hospital equipment, facilities and hospital personnel which are necessary to effectively exercise such privileges, within limits defined in ARTICLE VI, Part E, based upon an individual’s license, education, training, experience, competence and judgment.
 - (8) Words used in these bylaws shall be read as the masculine and feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.
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ARTICLE II CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board after receiving a recommendation from the Medical Executive Committee, and shall be to one of the following categories of the staff. All appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these bylaws and approved by the Board. Appointments/Reappointments shall not exceed a period of two years.

ARTICLE II - PART A: ACTIVE STAFF

The Active Staff shall consist of those physicians and dentists who have been advanced from the Associate Staff and who attend, admit or are involved in the treatment of at least 12 patients or performed 24 or more outpatient procedures per year at the hospital. Each appointee to the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments. Active Staff appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairpersons of such committees. They shall attend meetings as required by these Bylaws. Candidates for the Active Staff must have served on the Associate Staff for at least one year prior to becoming eligible for advancement to the Active Staff.

ARTICLE II - PART B: ASSOCIATE STAFF

The Associate Staff shall consist of physicians and dentists who will be considered for advancement to full staff status. Persons appointed to the Associate Staff shall not be entitled to vote, but may serve on Medical Staff committees (but not as chairpersons of committees) and shall attend meetings as required by these Bylaws. They shall be ineligible to hold elective office.

ARTICLE II - PART C: COURTESY STAFF

The Courtesy Staff shall consist of physicians and dentists who are qualified for Active Staff appointment but who do not desire Active status but who wish to admit an occasional patient to the hospital. Persons appointed to the Courtesy Staff may not vote and may not hold office, and may not admit more than twelve patients a year or perform more than 24 outpatient procedures per year at the hospital. If such physicians wish to exceed that number, they must join the Active Staff.

ARTICLE II - PART D: CONSULTING STAFF

The Consulting Staff shall consist of physicians or dentists appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients. Appointment to the Consulting Staff does not entitle the appointee to admit patients, to vote, to hold staff offices, or to serve on Medical Staff committees.

ARTICLE II - PART E: HONORARY STAFF

The Honorary Staff shall consist of Medical Staff appointees who have retired from active hospital practice or other physicians or dentists who are of outstanding reputation, not necessarily residing in the community. Persons appointed to the Honorary Staff shall not be eligible

to admit or attend patients, to vote, to hold office or to serve on standing Medical Staff committees, but may be appointed to special committees.

ARTICLE II - PART F: AFFILIATE STAFF

The Affiliate Staff shall consist of physicians and dentists who are otherwise eligible for staff membership, but because of distance or other reasons, do not wish to admit or treat patients at the hospital, but would like to avail themselves of the ancillary services provided such as laboratory, radiology, and home care services. Members of the Affiliate Staff may not vote or hold office and are not required to attend meetings or serve on committees.

ARTICLE II - PART G: EMERGENCY DEPARTMENT STAFF

The Emergency Department Staff shall consist of Emergency Department Physicians who are under contract with the hospital to provide emergency service to patients utilizing the Emergency Department of the hospital. Emergency Department Staff shall have active status on the Medical Staff with all privileges and rights associated therewith with the exception that they shall not have admitting privileges to the hospital.

ARTICLE II - PART H: CONTRACT PHYSICIANS

These are physicians who by virtue of contract with the hospital have some administrative duties in addition to their clinical duties. They shall be members of the Medical Staff and shall meet the requirements for continuing membership. Contractual services shall be governed by the terms of the contract with The Medical Center and shall not be subject to appeal as provided by these bylaws. Termination of the employment contract or relationship shall result in the automatic termination of Medical Staff membership if specified in the contract.

ARTICLE III

STRUCTURE OF THE MEDICAL STAFF

ARTICLE III - PART A: MEDICAL STAFF YEAR:

For the purpose of these bylaws the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year.

ARTICLE III - PART B: OFFICERS

The officers of the Medical Staff shall be the President, Vice President, President-Elect and Secretary.

ARTICLE III - PART B:

Section 1. Qualifications of Officers and Chairpersons:

Only those Medical Staff appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, department or committee chairpersons:

- (a) be appointed in good standing to the Active Medical Staff of the hospital and continue so during their term of office;
- (b) have demonstrated interest in maintaining quality medical care at the hospital and demonstrated commitment to the well-being of the hospital patient;
- (c) be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;
- (d) be knowledgeable concerning the hospital's organization and the duties of the office.
- (e) members of the Medical Staff serve as officers, chairpersons of departments and serve on committees as chairpersons or members on a strictly voluntary basis. Any compensation of a member of the Medical Staff for duties assigned by the President or mandated by the Medical Staff shall be approved by a majority of a quorum of the Medical Staff; and
- (f) the Chairperson of each Medical Staff department/service is certified by an appropriate specialty board, or affirmatively establishes, through the privilege delineation process, that the person possesses comparable competence.

All Medical Staff officers, committee and department chairpersons and service chiefs must possess the above qualifications and maintain such qualifications during their term of office.

ARTICLE III - PART B:

Section 2. President of the Medical Staff:

The President shall:

- (a) act in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the hospital;
 - (b) call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;
 - (c) appoint committee chairpersons and members, in accordance with the provisions of these bylaws, to all standing and special Medical Staff committees except the Medical Executive Committee;
 - (d) serve as Chairperson of the Medical Executive Committee;
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- (e) serve as ex officio member of all Medical Staff committees other than the Medical Executive Committee, and of all departments, without vote;
- (f) represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board through the Chief Executive Officer;
- (g) provide, on an as needed basis, day-to-day liaison on medical matters with the Chief Executive Officer and the Board; and
- (h) receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care.

ARTICLE III - PART B:

Section 3. Vice President of the Medical Staff:

The Vice President shall:

- (a) assume all the duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason;
- (b) serve on the Medical Executive Committee; and
- (c) perform such duties as are assigned by the President.

ARTICLE III - PART B:

Section 4. President-Elect:

The President-Elect shall:

- (a) serve on the Medical Executive Committee;
- (b) perform such duties as are assigned by the President; and
- (c) serve as Chairperson of the Performance Improvement Coordinating Committee.

ARTICLE III - PART B:

Section 5. Secretary:

The Secretary shall:

- (a) serve on the Medical Executive Committee;
- (b) cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;
- (c) call Medical Staff meetings on order of the President of the Medical Staff and record attendance;
- (d) attend to all correspondence and perform such other duties as ordinarily pertain to the office of Secretary; and
- (e) serve as treasurer.

ARTICLE III - PART B:

Section 6. Election of Officers:

- (a) The President of the Medical Staff shall appoint a Nominating Committee consisting of five Active Staff appointees. The Nominating Committee shall prepare a slate of nominees for each office to be filled at that election. The slate of nominees shall be posted sixty days prior to the election.
 - (b) Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and by any other Medical Staff appointee prior to each annual Medical Staff meeting. Any nomination made by an appointee other than the Nominating Committee must be submitted, in writing, to the Nominating Committee at least seven days prior to
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- the election. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Section 1 of this Part. The candidates who receive a majority vote of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. The vote shall be by written secret ballot. The President of the Medical Staff shall designate a person or persons to count the ballots. Each officer shall then serve from the start of the next Medical Staff year (January 1) for a term of one year or until a successor has been elected.
- (c) In any election, if there are three or more candidates for an office and no candidate receives a majority vote there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

ARTICLE III - PART B:

Section 7. Removal of Officers:

The Medical Staff by a 2/3 majority vote may remove any Medical Staff officer for conduct detrimental to the interests of the hospital and the Medical Staff, failure to maintain the qualifications listed in Article III, Part B, Section 1, or if the officer is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of that office, providing that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

ARTICLE III - PART B:

Section 8. Vacancies in Office:

If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President's term, the Vice President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the President of the Medical Staff shall appoint another appointee possessing the qualifications set forth in Section 1 of this Part to serve out the remainder of the unexpired term.

ARTICLE III - PART C: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Staff Meeting:

The Medical Staff shall meet at least once annually. The November meeting shall be the annual meeting at which officers for the ensuing year shall be elected.

ARTICLE III - PART C:

Section 2. Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the Medical Executive Committee or a petition signed by not less than one-fourth of the voting staff.

ARTICLE III - PART C:

Section 3. Quorum:

The presence of 20% of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding only as long as a quorum exists.

ARTICLE III - PART C:

Section 4. Agenda:

The agenda at any regular Medical Staff meeting and its conduct shall be set by the President of the Medical Staff. The agenda of a special meeting shall be limited to those topics for which the meeting was called.

ARTICLE III - PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings:

Members of each department shall meet as a department at least annually at a time set by the chairperson of the department to review and evaluate the clinical work of the department, to consider the findings of ongoing quality measurement and improvement activities, and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairperson. Each department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting, to the Medical Executive Committee and the Chief Executive Officer.

ARTICLE III - PART D:

Section 2. Committee Meetings:

All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairperson of the committee. The agenda for the meeting and its general conduct shall be set by the chairperson. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the Medical Executive Committee and the Chief Executive Officer.

ARTICLE III - PART D:

Section 3. Special Department and Committee Meetings:

- (a) A special meeting of any committee or department may be called by or at the request of the chairperson, the President of the Medical Staff, or by a petition signed by not less than one-fourth of the members of the department or committee. The agenda of special meetings shall be restricted to the purpose for which the special meeting was called.

ARTICLE III - PART D:

Section 4. Quorum:

The presence of one-third of the total membership of the committee or department eligible to vote at any regular or special meeting (but in no event less than two members) shall constitute a quorum for all actions. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding only as long as a quorum exists.

ARTICLE III - PART D:

Section 5. Minutes:

Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Medical Executive Committee and, at the same time, to the Chief Executive Officer and certain committees as specified elsewhere in these bylaws. A permanent file of the minutes of each committee and each department meeting shall be maintained by the hospital.

ARTICLE III - PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of departments and committees shall be posted on the Medical Staff bulletin board or delivered either in person or by mail to each Medical Staff appointee at least five working days in advance of such meetings. Such notice shall state the date, time and place of the meeting. If mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each appointee at his address as it appears on the records of the hospital. Such posting or mailing shall be deemed to constitute actual notice to the persons concerned. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

ARTICLE III - PART E:

Section 2. Attendance Requirements:

- (a) There shall be no meeting attendance requirements except for the following: Physicians serving on the Medical Staff Credentials Committee or the Medical Executive Committee shall be required to attend at least 50% of the meetings held.
- (b) Any Medical Staff appointee whose clinical work is scheduled for discussion at a regular departmental meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, the chairperson of the department shall give the individual three weeks advance written notice of the time, place and content of the meeting at which attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by certified mail, return receipt requested, and the individual's attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.
- (c) The chairperson of the applicable department shall notify the Medical Executive Committee of the failure of an individual to attend any meeting with respect to which notice was given that attendance was mandatory. Unless excused by the Medical Executive Committee after an opportunity for the affected individual to be heard, upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's admitting privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement, supported by an adequate showing that the absence will be unavoidable, the presentation may be postponed by the chairperson of the individual's department, or by the Medical Executive Committee if the department chairperson is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE III - PART E:

Section 3. Rules of Order:

Wherever they do not conflict with these bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

ARTICLE III - PART E:

Section 4. Voting:

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

ARTICLE IV CLINICAL DEPARTMENTS AND SERVICES

ARTICLE IV - PART A: CLINICAL DEPARTMENTS AND SERVICES

Section 1. List of Departments and Services:

The following clinical departments and services are established. Additional departments or services, as required from time to time, may be established upon recommendation from the Medical Executive Committee, or the hospital subject to confirmation by the Medical Staff and the Board.

- (a) Departments:
 - (1) Medicine
 - (2) Surgery
 - (3) Obstetrics & Gynecology
 - (4) Pediatrics

- (b) Clinical Services:
 - (1) Anesthesiology
 - (2) Pathology
 - (3) Radiology

The services and Chiefs of services shall be subject to the requirements of this Article pertaining to departments and departmental chairpersons.

ARTICLE IV - PART A:

Section 2. Functions of Departments:

- (a) Each clinical department chairperson shall recommend to the Medical Staff Credentials Committee written criteria for the assignment of clinical privileges within the department and each of its divisions. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the Medical Staff and the hospital. Clinical privileges shall be based upon demonstrated competence, training and experience within the specialty covered by the department.
- (b) Each department shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the department or division. This monitoring and evaluation must at least include:
 - (1) the routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members; and
 - (2) the periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care.

Each department shall recommend, subject to approval and adoption by the Medical Executive Committee, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the hospital's performance improvement program in the measurement and improvement of patient care. When important problems in patient care and clinical performance or opportunities to improve

care are identified, each department shall document the actions taken and evaluate the effectiveness of such actions.

- (c) In discharging these functions, each department shall report after each meeting to the Performance Improvement Coordinating Committee detailing its analysis of patient care. Whenever further investigation and action is indicated, involving any individual member of the department, the physician will be notified prior to any information being provided to the Medical Staff Credentials Committee. Copies of these reports shall be filed with the Medical Executive Committee and the Chief Executive Officer.

ARTICLE IV - PART A:

Section 3. Department Chairpersons:

- (a) The chairperson and the vice chairperson of each department shall be an appointee to the Active Staff who possesses the qualifications set forth in Article III, Part B, Section 1 of these bylaws.
- (b) The chairperson and the vice chairperson of each department shall be elected by the department members. The initial term of a chairperson shall be made for a period of one year. Re-election in the same manner may be made yearly thereafter.
- (c) Removal of a chairperson or a vice chairperson during a term of office may be initiated by a two-thirds vote of all Active Staff appointees in the department.

ARTICLE IV - PART A:

Section 4. Functions of Department Chairpersons:

Each chairperson shall:

- (a) be responsible for the continuous assessment and improvement of the quality of care, treatment and services in the department and the maintenance of quality control programs as appropriate;
 - (b) be responsible for clinically related activities of the department and administrative activities within the department;
 - (c) be a member of the Medical Executive Committee;
 - (d) maintain continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department, and report thereon to the Medical Staff Credentials Committee as part of the reappointment process and at such other times as may be indicated;
 - (e) recommend criteria for clinical privileges in the department;
 - (f) develop and implement policies and procedures that guide and support the provision of care, treatment and services within the department and be responsible for enforcement within the department of the hospital policies and bylaws and the Medical Staff bylaws, policies, rules and regulations;
 - (g) be responsible for implementation within the department of actions taken by the Board and the Medical Executive Committee;
 - (h) recommend and make a report to the Medical Staff Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the department;
 - (i) be responsible for the orientation and continuing education of all persons in the department;
 - (j) report and recommend to hospital management when necessary with respect to matters affecting patient care in the department, including personnel, supplies, space and other resources, special regulations, standing orders and techniques;
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- (k) assess and recommend off site sources for needed patient care, treatment and services not provided by the department or the organization;
 - (l) assist the hospital management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Chief Executive Officer or the Board; and
 - (m) delegate to a vice chairperson of the department such duties as appropriate.
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ARTICLE V COMMITTEES OF THE MEDICAL STAFF

ARTICLE V - PART A: APPOINTMENT

Section 1. Chairpersons:

- (a) All committee chairpersons, unless otherwise provided for in these bylaws, will be appointed by the President of the Medical Staff. All chairpersons shall be selected based on the criteria set forth in these bylaws.
- (b) Such appointments will be given on January 1 and the initial term will be for one year. After serving an initial term, a chairperson may be reappointed in the same manner.

ARTICLE V - PART A:

Section 2. Members:

- (a) Except as otherwise provided for in these bylaws, physician members of each committee shall be appointed yearly by the President of the Medical Staff, in consultation with the Chief Executive Officer, not more than 10 days after the end of the Medical Staff year, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed for cause and vacancies filled at the discretion of the President of the Medical Staff. The Chief Executive Officer, or his designee, after consultation with the President, shall assign appropriate hospital management, nursing, or other personnel, as appropriate, to serve on committees, but without vote unless it is a multidisciplinary hospital wide committee.
- (b) The Chief Executive Officer or designee, and the President of the Medical Staff shall be members, ex officio, without vote, on all committees.

ARTICLE V - PART B: MEDICAL EXECUTIVE COMMITTEE

Section 1. Composition:

- (a) The Medical Executive Committee shall consist of the officers of the Medical Staff, the chairperson of each clinical department, the chiefs of the services of Radiology, Pathology, and Anesthesiology, the vice chairpersons of the Departments of Medicine and Surgery, and the Immediate Past President.
- (b) The President of the Medical Staff shall be chairperson of the Medical Executive Committee.
- (c) The Chief Executive Officer or designee attends meetings of the Medical Executive Committee and participates in its discussions, but without vote.

ARTICLE V - PART B:

Section 2. Duties:

The duties of the Medical Executive Committee shall be:

- (a) to represent and to act in between its regular meetings, on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by these bylaws, provided that a summary of Executive Committee actions will be reported in an appropriate and timely manner to the staff;
 - (b) to coordinate the activities and general policies of the various departments;
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- (c) to receive and to act upon reports of Medical Staff committees, departments, and other assigned groups as specified in these bylaws, and to make recommendations concerning them to the Chief Executive Officer and the Board;
- (d) to implement policies of the hospital that affect the Medical Staff;
- (e) to provide liaison among the Medical Staff, the Chief Executive Officer and the Board;
- (f) to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;
- (g) to enforce hospital and Medical Staff rules in the best interest of patient care and of the hospital, with regard to all persons who hold appointment to the Medical Staff;
- (h) to refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee to the Medical Staff Credentials Committee or special committee for appropriate action;
- (i) to be responsible to the Board for the implementation of the hospital's performance improvement plan as it affects the Medical Staff; and
- (j) to review the bylaws, policies, rules and regulations, and associated documents of the Medical Staff as needed and recommend such changes as may be necessary or desirable.

ARTICLE V - PART B:

Section 3. Meetings. Reports and Recommendations:

- (a) the Medical Executive Committee shall meet as often as necessary to transact pending business. The Secretary will maintain reports of all meetings, which shall include the reports of the various committees and departments of the staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Chief Executive Officer routinely as prepared. Recommendations of the Medical Executive Committee shall be transmitted to the Board through the Chief Executive Officer. The Chairperson of the Medical Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Medical Executive Committee may make.

ARTICLE V - PART C: CREDENTIALS COMMITTEE

Section 1. Composition:

The Medical Staff Credentials Committee shall consist of five Active Staff appointees, three of whom are the most recent Past Presidents who are still appointees to the Active Staff and who are willing to serve, and two additional members appointed by the President of the Medical Staff who shall meet the qualifications set forth in Article III, Part B, Section 1 of these bylaws. The chairperson of the committee shall be that Past President member with the greatest seniority. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere. The Chairperson of the Board or designee may attend meetings of the Medical Staff Credentials Committee and participate in its discussions, but without vote. The President of the Medical Staff shall appoint up to five additional members to the committee, for terms of one year each, if at any time the continued workability of the committee is threatened by the inability or unwillingness of any committee member to serve.

ARTICLE V - PART C:

Section 2. Duties:

The duties of the Medical Staff Credentials Committee shall be:

- (a) to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a report of its findings and recommendations;
- (b) to review the credentials of all applicants who request to practice at the hospital as Medical Associates, to make investigations of and interview such applicants as may be necessary, and to make a report of its findings and recommendations;
- (c) to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Medical Associates, as a result of such review, to make a report of its findings and recommendations; and
- (d) to approve criteria for clinical privileges upon recommendation by department chairs.

ARTICLE V - PART C:

Section 3. Meetings. Reports and Recommendations:

The Medical Staff Credentials Committee shall meet at least quarterly or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee which will forward its recommendation to the Board through the Chief Executive Officer. The Chairperson of the Medical Staff Credentials Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Medical Staff Credentials Committee may make.

ARTICLE V - PART D: PERFORMANCE IMPROVEMENT COORDINATING COMMITTEE

Section 1. Composition:

The Performance Improvement Coordinating Committee shall be a multidisciplinary hospital wide committee with three active staff appointees.

ARTICLE V - PART D:

Section 2. Duties:

The Performance Improvement Coordinating Committee shall assume the responsibility for directing the ongoing development and maintenance of the Performance Improvement Program as it affects the Medical Staff. Specifically the committee shall:

- (a) coordinate the medical review activities of all clinical departments;
 - (b) review all patient care evaluation studies and efforts by medical review committees to comply with the hospital's Performance Improvement Program, and make appropriate recommendations for corrective action;
 - (c) receive and review reports of other medical care evaluation and patient care committees and groups to ensure that prospective and retrospective studies are appropriately integrated into the Performance Improvement Program;
 - (d) assign tasks and responsibilities to departments, committees and/or individuals in order to identify and resolve patient care problems and institutional waste and duplication; and
 - (e) document the effectiveness of the overall Performance Improvement Program as it pertains to the Medical Staff.
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ARTICLE V - PART D:

Section 3. Meetings, Reports and Recommendations:

The Performance Improvement Coordinating Committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and recommendations, and shall make a report thereof after each meeting to the Medical Executive Committee and the Chief Executive Officer.

ARTICLE V- PART E: ETHICS COMMITTEE

Section 1. Composition:

The Ethics Committee shall be a multidisciplinary hospital wide committee with at least four active staff appointees.

ARTICLE V- PART E: ETHICS COMMITTEE

Section 2. Duties:

The Ethics Committee shall serve as a resource committee to consider issues of medical ethics presented by physicians, hospital staff, or patients. The Committee shall serve in an advisory capacity on questions of ethical conduct or ethical codes and assist in the development of policy and procedures involving ethical issues.

ARTICLE V- PART E: ETHICS COMMITTEE

Section 3. Meetings, Reports and Recommendations:

The Ethics Committee shall meet at least quarterly and report to the Medical Executive Committee on matters affecting the Medical Staff.

ARTICLE V - PART F: SCOTTSVILLE COMMITTEE

Section 1. Composition:

The Scottsville Committee shall consist of any physician who performs at least 75% of his or her hospital practice at the Scottsville campus.

ARTICLE V - PART F

Section 2. Duties:

The Committee shall elect a Chairperson and shall be responsible for performing those required functions of the Medical Staff that apply to physicians and other practitioners who function at the Scottsville campus, which functions have been delegated to the Committee by the Executive Committee of the Medical Staff or by the governing board of The Medical Center.

ARTICLE V - PART F

Section 3. Meetings, Reports and Recommendations:

The Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its findings, proceedings and actions, and report to the Medical Executive Committee.

ARTICLE V - PART G: STAFF FUNCTIONS

Provision shall be made in these Bylaws or by resolution of the Medical Executive Committee either through assignment to the departments, to staff committees, to staff members, or to interdisciplinary Hospital Teams, for the effective performance of the staff functions specified in this Section. These are to:

- (a) Measure, assess and improve the care provided in and develop clinical policy for special care areas, patient care support services, emergency and other ambulatory care services;
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- (b) Conduct or coordinate the measurement, assessment and improvement activities, including, but not limited to, medical assessment and treatment, use of medications, use of blood and blood components, performance of operative and other procedures, patient safety, and sentinel events, patient satisfaction, education of patients and family, and significant departures from established patterns of clinical practice;
- (c) Conduct or coordinate medical record review activities including accurate, timely and legible completion of patient's medical records;
- (d) Conduct or coordinate utilization review activities;
- (e) Develop and maintain surveillance over drug utilization policies and practices;
- (f) Monitor the Hospital's infection control program and investigate and address nosocomial infections;
- (g) Coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;
- (h) Engage in other functions reasonably requested by the Medical Executive Committee; and
- (i) Communicate findings, actions and recommendations to the Performance Improvement Coordinating Committee and the Medical Executive Committee.

ARTICLE V-PART H: CREATION AND DISSOLUTION OF COMMITTEES

Except for Standing Committees, the Executive Committee of the Medical Staff may by resolution, without amendment to these bylaws, establish additional Ad Hoc Committees to perform one or more staff functions. In the same manner the Medical Executive Committee may, by resolution, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions subject to notification of the Medical Staff at its next meeting. The Ad Hoc Committee term shall coincide with the Medical Executive Committee. Standing Committees may be added or dissolved through amendment to these bylaws. Any function required to be performed by these Bylaws which is not assigned to a Standing or Special Committee or team shall be performed by the Medical Executive Committee.

ARTICLE V-PART I: SPECIAL COMMITTEES

The President of the Medical Staff may, at the request of the hospital, appoint physicians to hospital committees or to serve as liaison with services as needed to enhance communications with the Medical Staff.

ARTICLE VI APPOINTMENT TO THE MEDICAL STAFF

ARTICLE VI - PART A: QUALIFICATIONS FOR APPOINTMENT

Section 1. General:

Appointment to the Medical Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Medical Staff bylaws and in such hospital policies as are adopted from time to time by the Medical Staff and the Board. All individuals practicing medicine and dentistry in this hospital, unless excepted by specific provisions of the Medical Staff bylaws, must first have been appointed to the Medical Staff.

ARTICLE VI - PART A:

Section 2. Specific Qualifications:

Only physicians and dentists who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

- (a) are currently licensed to practice in this state, and if applicable, hold a valid Drug Enforcement Administration registration;
- (b) are located within the geographic service area of the hospital as defined by the Chief Executive Officer or designee, close enough to provide timely care for their patients;
- (c) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital; and
- (d) can document:
 - (1) background, experience, training and demonstrated competence,
 - (2) adherence to the ethics of their profession,
 - (3) good reputation and character, including the applicant's physical health and mental and emotional stability,
 - (4) professional cooperation with hospital staff in providing quality and orderly patient care, and
 - (5) they are the individual identified in the credentialing documents by presenting a government issued picture identification prior to providing services in or by the hospital.

ARTICLE VI - PART A:

Section 3. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that such individual:

- (a) is licensed to practice a profession in this or any other state,
 - (b) is a member of any particular professional organization,
 - (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital, or
 - (d) resides in the geographic service area of the hospital as defined by the Chief Executive Officer.
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ARTICLE VI - PART A:

Section 4. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, age, race, creed, religion, color or national origin, or handicap.

ARTICLE VI - PART B: CONDITIONS OF APPOINTMENT

Section 1. Duration of Initial Appointment:

All initial appointments to the Medical Staff shall be for period not to exceed two years, regardless of the category of the staff to which the appointment is made and all initial clinical privileges shall be provisional for a period of 12 months from the date of the appointment or longer if recommended by the Medical Staff Credentials Committee. During the term of this provisional appointment, the individual receiving the provisional appointment shall be evaluated by the chairperson of the department or departments in which the individual has clinical privileges, and by the relevant committees of the Medical Staff and the hospital as to the individual's clinical competence and general behavior and conduct in the hospital. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment.

ARTICLE VI - PART B:

Section 2. Rights and Duties of Appointees:

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Board and the Medical Staff shall require.

ARTICLE VI - PART B:

Section 3. Time Requirements for Promotion:

The period of time and qualification requirements stated in these policies and procedures for promotion from Associate to Active Staff may be altered as to specific applicants on recommendation of the Medical Staff Credentials Committee and the Medical Executive Committee and approval of the Board.

ARTICLE VI - PART C: APPLICATION FOR INITIAL APPOINTMENT
AND CLINICAL PRIVILEGES

Section 1. Information:

All requests for applications shall be made in writing to the Chief Executive Officer or designee. A preapplication form will be sent in response to all requests for an application. The preapplication form will elicit information from the potential applicant about the proposed scope of medical service as well as inform the potential applicant about the current status of any closed Medical Staff services. The process of closing Medical Staff services will be jointly developed by the Medical Staff and the hospital with the Board retaining the ultimate authority. Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on the appropriate forms. These forms shall be obtained from the Chief Executive Officer or designee. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

- (a) the names and complete addresses of at least two peers in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and
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- who can provide adequate information pertaining to the applicant's present professional competence and character, and who are not associated or about to be associated with the applicant in professional practice or personally related to the applicant.
- (b) the names and complete addresses of the chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials and Executive Committees and the Board may take into consideration the applicant's good faith effort to produce this information;
 - (c) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been relinquished, denied, revoked, suspended, voluntary or involuntary limitation, reduction, or loss of clinical privileges, or terminated either voluntarily or involuntarily, or not renewed at any other hospital or health care facility, or are currently being challenged;
 - (d) information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment and/or clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;
 - (e) information as to whether the applicant's membership in local, state or national professional societies, or license to practice any profession in any state, or Drug Enforcement Administration or controlled substances registration number is or has ever been suspended, modified, terminated, relinquished either voluntarily or involuntarily, restricted or is currently being challenged. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his/her Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed;
 - (f) proof that the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;
 - (g) information concerning applicant's malpractice litigation experience, specifically information concerning final judgment, pending lawsuits and settlements;
 - (h) a consent to the release of information from the applicant's present and past professional liability insurance carriers;
 - (i) information on the applicant's physical and mental health;
 - (j) information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance;
 - (k) information on the citizenship and visa status of the applicant;
 - (l) information as to whether the applicant has ever been excluded from participation in any federal or state healthcare program; and
 - (m) the applicant's signature.

ARTICLE VI - PART C:

Section 2. Undertakings:

The following undertakings shall be applicable to every Medical Staff applicant and appointee for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

- (a) an obligation upon appointment to the Medical Staff to provide continuous care and supervision and the same level of quality of care to all patients within the hospital for whom the individual has responsibility;

- (b) an agreement to abide by all bylaws and policies of the hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force from time to time during the time the individual is appointed to the Medical Staff;
- (c) an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to the applicant after appointment by the Board;
- (d) an agreement to provide the hospital new or updated information as it occurs, that is pertinent to any question on the application form;
- (e) a statement that the applicant has received and had an opportunity to read a copy of the bylaws of the hospital and the bylaws, rules and regulations of the Medical Staff as are in force at the time of his/her application and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment to the Medical Staff or clinical privileges;
- (f) a statement of the applicant's willingness to appear for personal interviews in regard to his/her application;
- (g) a statement that any substantial misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for suspension of process and may result in the rejection of the application and denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Medical Staff; and
- (h) a statement that the applicant will provide or arrange for continuous care for the applicant's patients in the hospital.

Each applicant for Medical Staff appointment and reappointment shall specifically agree to these undertakings as part of the application.

ARTICLE VI - PART C:

Section 3. Burden of Providing Information:

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct. Until the applicant has provided all information requested by the hospital, the application for appointment or reappointment will be deemed incomplete and will not be processed. Should an incident (bearing upon a proper evaluation of his/her competence, character, ethics and other qualifications) occur during the course of an appointment year, the appointee has the burden to provide information about such incident sufficient for the Medical Staff Credentials Committee's review and assessment.

ARTICLE VI - PART C:

Section 4. Authorization to Obtain Information:

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff and to all others having or seeking clinical privileges at the hospital. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

(a) Immunity:

In accordance with these bylaws and any requirement imposed by law, to the fullest extent permitted by law, the individual releases from any and all liability and extends absolute immunity to the members of the Medical Staff, the hospital, its authorized representatives and any third parties as defined in subsection (d) below, with respect to any acts, communications or documents, recommendations or disclosures involving the individual, concerning the following:

- (1) applications for appointment or clinical privileges, including temporary privileges;
- (2) evaluations concerning reappointment or changes in clinical privileges;
- (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
- (4) summary suspension;
- (5) hearings and appellate reviews;
- (6) medical care evaluations;
- (7) utilization reviews;
- (8) other activities relating to the quality of patient care or professional conduct;
- (9) matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or
- (10) any other matter that might directly or indirectly relate to the individual's competence, to provide patient care, or to the orderly operation of this or any other hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

(b) Authorization to Obtain Information:

The individual specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

(c) Authorization to Release Information:

Similarly, the individual specifically authorizes the hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

(d) Definitions:

- (1) As used in this section, the term "hospital and its authorized representatives" means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct at the hospital: the members of its Board and their appointed representatives; the Chief Executive Officer or designee; other hospital employees; consultants to the hospital; the hospital's
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attorney and his/her partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct at the hospital.

- (2) As used in this section, the term "third parties" means all individuals, including appointees to the hospital's Medical Staff, and appointees to the Medical Staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

ARTICLE VI - PART D: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Submission of Application:

The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or designee. After verifying the information from the primary sources (current licensure, relevant training and current competence) whenever feasible and collecting references and other information or materials deemed pertinent, the Chief Executive Officer or designee shall determine the application to be complete and transmit the application and all supporting materials to the applicable department chairperson at the earliest possible time. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. It is the responsibility of the applicant to provide that the application is complete, including adequate responses from references. An incomplete application will not be processed. Each applicant's name shall be posted on the Medical Staff bulletin board prior to action by the Medical Staff Credentials Committee.

ARTICLE VI - PART D:

Section 2. Department Chairperson Procedure:

The Chairperson of each department in which the applicant seeks clinical privileges shall provide the Medical Staff Credentials Committee with a report containing an appraisal of the applicant's qualifications for appointment and specific written findings supporting the proposed delineation of the applicant's clinical privileges. This report shall be made a part of the Medical Staff Credentials Committee's report. As part of the process of making this report, the department chairperson has the right to meet with the applicant to discuss any aspect of his/her application, qualifications and requested clinical privileges.

ARTICLE VI - PART D:

Section 3. Subsequent Medical Staff Credentials Committee Procedure:

- (a) The Medical Staff Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, including an appraisal from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for clinical privileges requested.
 - (b) In addition, any current Medical Staff appointee shall have the right to appear in person before the Medical Staff Credentials Committee to discuss in private and in confidence any concerns the committee may have about the applicant.
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- (c) As part of this process, the Medical Staff Credentials Committee may require a physical and mental examination of the applicant by a physician or physicians satisfactory to the Medical Staff Credentials Committee and shall require that the results be made available for the Committee's consideration.
- (d) If, after considering the report of the clinical department chairperson or chief concerned, the Medical Staff Credentials Committee's recommendation for appointment is favorable, the Medical Staff Credentials Committee shall recommend provisional department assignment and provisional clinical privileges.
- (e) As part of the process of making its recommendation, the Medical Staff Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.

ARTICLE VI - PART D:

Section 4. The Medical Staff Credentials Committee Report:

- (a) Not later than 90 days from its receipt of the application and all required and requested information, the Medical Staff Credentials Committee shall make a written report and recommendation with respect to the applicant to the Medical Executive Committee, with a copy to the Chief Executive Officer;
- (b) If the recommendation of the Medical Staff Credentials Committee is delayed longer than 90 days, the Chairperson of the Medical Staff Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and Chief Executive Officer, explaining the delay.
- (c) The Medical Staff Credentials Committee shall transmit to the Medical Executive Committee the application and all supporting documentation and its recommendation that the applicant be appointed to the Medical Staff, that the applicant's application be deferred for further consideration, or that the applicant be rejected for Medical Staff appointment. The Chairperson of the Medical Staff Credentials Committee shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to the recommendation.

ARTICLE VI - PART D:

Section 5. Medical Executive Committee Procedure:

- (a) At its next regular meeting after receipt of the application, report and recommendation of the Medical Staff Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Board that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application for staff appointment or clinical privileges be denied. The recommendation of the Medical Executive Committee together with all supporting documentation shall be forwarded to the Board and the Chief Executive Officer. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.
 - (b) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within 30 days with a subsequent recommendation to the Board and the Chief Executive Officer for appointment to the Medical Staff with specified clinical privileges, or for denial of the application for staff appointment.
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- (c) When the Medical Executive Committee has determined to make a recommendation contrary to the recommendation of the Medical Staff Credentials Committee, the Medical Executive Committee shall either:
- (1) remand the matter to the Medical Staff Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Executive Committee prior to the Medical Executive Committee's final recommendation; or
 - (2) set forth in its report and recommendation to the Board the specific reasons for the Medical Executive Committee's disagreement with the Medical Staff Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or the Medical Staff Credentials Committee's report.
- (d) When the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing pursuant to these bylaws, it shall be forwarded to the Chief Executive Officer who shall promptly so notify the applicant in writing, return receipt requested. The Chief Executive Officer shall then hold the application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Article VIII, after which the Chief Executive Officer shall forward the recommendation of the Medical Executive Committee, together with the application and all supporting documentation, to the Board.

ARTICLE VI - PART E: CLINICAL PRIVILEGES

Section 1. General:

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each individual who has been given an appointment to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated current competence and judgment, references, including peer recommendations, health status, availability of qualified medical coverage, adequate levels of professional liability insurance coverage, the hospital's available resources and personnel, whether applicant has ever been excluded from participation in any federal or state healthcare program, and information concerning any previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration, information concerning any voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant, relevant practitioner specific data compared to aggregate data when available, performance measurement data including morbidity and mortality data, when available, and other relevant information, including findings by the chairperson of each of the clinical departments in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications for and competence to exercise the clinical privileges requested.

The reports of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Medical Staff Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

ARTICLE VI - PART E:*Section 2. Clinical Privileges for Dentists:*

- (a) The scope and extent of surgical procedures that a dentist may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (b) Oral surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Medical Staff Credentials Committee. The oral surgeon shall obtain an appropriate medical consultation if indicated. "Oral surgeons" shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.
- (c) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations and in compliance with the hospital and Medical Staff Bylaws.

ARTICLE VI - PART F: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES*Section 1. Temporary Clinical Privileges for Applicants:*

Temporary privileges shall not routinely be granted to applicants. Under certain circumstances temporary clinical privileges may be granted for a limited period of time: 1. To fulfill an important patient care, treatment, and service need. 2. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board. Temporary privileges may be granted upon verification of the following: current licensure, relevant training or expertise, current competency, ability to perform the privileges requested, a query and evaluation of the National Practitioner Data Bank information, a complete application, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges. The Chief Executive Officer may after consulting with either the President of the Medical Staff, the Medical Staff Credentials Committee or the appropriate Departmental Chair, grant temporary privileges to an applicant for a time period not to exceed one hundred and twenty days (120). The Chief Executive Officer shall notify the President of the Medical Staff when temporary privileges are granted. In exercising such privileges, the applicant shall act under the supervision of the chairperson or designee of the department in which the applicant has requested primary privileges.

ARTICLE VI - PART F:*Section 2. Temporary Clinical Privileges for Non Applicants:*

Temporary admitting and clinical privileges for care of a specific patient or patients may be initially granted for no longer than 15 days by the Chief Executive Officer with the concurrence of

the chairperson of the department concerned, and the President of the Medical Staff to a physician who is not an applicant for appointment in the same manner and upon the same conditions as set forth in Section 1 of this Part, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment that he/she agrees to be bound by the hospital bylaws, and Medical Staff Bylaws, Rules and Regulations then in force in all matters relating to his/her temporary clinical privileges. Such privileges shall be restricted to the specific patients for which they are granted.

ARTICLE VI - PART F:

Section 3. Termination of Temporary Clinical Privileges:

- (a) Temporary privileges shall be immediately terminated at such time as the Medical Staff Credentials Committee recommends not to appoint, with respect to the applicant's application for Medical Staff membership. At the Medical Staff Credentials Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Medical Staff Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.
- (b) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the hospital. Neither the granting, denial or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in the Medical Staff Bylaws with respect to hearings or appeals.
- (c) Temporary privileges shall be automatically terminated at such time as the appointment to the staff. At the Medical Staff Credentials Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Medical Staff Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.

ARTICLE VI - PART G:

Section 1. Emergency Clinical Privileges:

- (a) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) or in which the life of a patient(s) is in immediate danger and any delay in administering treatment would add to that harm or danger.
- (b) In an emergency a Medical Staff member with clinical privileges is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm, regardless of his/her Medical Staff status of clinical privileges, provided that the care, treatment, and services provided are within the scope of the individual's license.
- (c) In the event that a disaster has been declared as outlined in the organization's emergency management plan, disaster privileges may be granted to volunteers eligible to be licensed independent practitioners. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. Disaster privileges may be granted by the Chief Executive Officer or the President of the Medical Staff or their designee(s). While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - 1) A current picture hospital ID card that clearly identifies professional designation;
 - 2) A current license to practice;
 - 3) Primary source verification of the license;
 - 4) Identification

indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups; 5) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); and 6) Identification by current hospital or Medical Staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. *Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g. no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.* The Medical Staff oversees the professional practice of volunteer licensed independent practitioners. Disaster privileges will expire at the time the Chief Executive Officer or designee declares the conclusion of the disaster and/or there is no further need for volunteer licensed independent practitioners.

ARTICLE VI - PART H: PROCEDURE FOR REAPPOINTMENT

Section 1. Application:

Each current appointee who wishes to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form. The reappointment application shall be submitted to the Chief Executive Officer or designee at least four months prior to the expiration of the appointee's then current appointment. Failure to submit an application by that time will result in expiration of the appointee's appointment and clinical privileges at the end of the current appointment. Two notices shall be sent, the first at six months prior to expiration and the second at five months prior to expiration with the second notice to be sent by certified mail return receipt requested. Such expirations shall be specifically evaluated by the Medical Executive Committee. Reappointment, if granted, shall be for a period of not more than two years.

ARTICLE VI - PART H:

Section 2. Factors to be Considered:

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based solely upon such appointee's:

- (a) ethical behavior, clinical competence and clinical judgment in the treatment of patients;
 - (b) attendance at required meetings and participation in staff duties, except that attendance to a patient under emergency conditions will not cause a physician to be removed from the staff;
 - (c) compliance with the hospital policies and with the Medical Staff Bylaws and Rules and Regulations;
 - (d) Professional cooperation with hospital staff in providing quality and orderly patient care;
 - (e) physical, mental and emotional health;
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- (f) capacity to satisfactorily treat patients within the scope of their privileges as indicated by the results of the hospital's quality measurement and improvement activities, including relevant practitioner specific data compared to aggregate data and morbidity and mortality data if available, peer recommendations or other reasonable indicators of continuing qualifications;
- (g) satisfactory completion of such continuing education requirements as may be imposed by law, the Medical Executive Committee, Board of Directors or applicable accreditation agencies;
- (h) other relevant findings from the hospital's quality measurement and improvement activities;
- (i) current licensure, which has been verified from the primary source, including currently pending challenges to any licensure or registration;
- (j) voluntary or involuntary relinquishment of any licensure or registration;
- (k) involvement in a professional liability action, including final judgment and settlements involving a practitioner; and
- (l) voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privilege at another hospital.

ARTICLE VI - PART H:

Section 3. Department Procedure:

- (a) No later than three months prior to the end of the current appointment period, the Chief Executive Officer shall send to the Medical Staff Credentials Committee the applications of all appointees desiring reappointment during that reappointment cycle. The Medical Staff Credentials Committee shall then in turn transmit to the chairperson of each department a current list of all appointees who have clinical privileges in that department, together with the clinical privileges each then holds, accompanied by copies of their applications.
- (b) No later than 15 days after receipt of the application, the chairperson of each department shall transmit to the Medical Staff Credentials Committee a report for each individual seeking reappointment in the same Medical Staff category with the same clinical privileges the applicant then holds. In addition, the chairperson shall submit individual reports, and the reasons therefore, for any changes recommended in staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not.
- (c) Criteria for evaluating requests for increase or decrease of clinical privileges shall be based upon:
 - (1) relevant recent training;
 - (2) observation of patient care provided;
 - (3) review of the records of patients treated in this or other hospitals;
 - (4) results of the hospital's quality measurement and improvement activities; and
 - (5) other reasonable indicators of the individual's continuing qualifications for the privileges in question such as peer recommendations.

ARTICLE VI - PART H:

Section 4. Medical Staff Credentials Committee Procedure:

- (a) The Medical Staff Credentials Committee, after receiving the reports from the chairperson of each department, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from hospital management for the purpose of determining its recommendations for staff reappoint-
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- ment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.
- (b) The Medical Staff Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Medical Staff Credentials Committee and the applicant either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued and make results available for the Medical Staff Credentials Committee's consideration. Failure of an individual seeking reappointment to procure such an examination within six (6) weeks after being requested to do so in writing by the Medical Staff Credentials Committee shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the Medical Staff Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. They will state the reason for the request and cite specific deficiencies to be evaluated.
 - (c) If, during the processing of a particular individual's reappointment, it becomes apparent to the Medical Staff Credentials Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Medical Staff Credentials Committee will notify the individual of the general tenor of the possible recommendation and ask the individual if he/she desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual will be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in the Medical Staff Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report whether such a meeting occurred.
 - (d) The Medical Staff Credentials Committee shall transmit its report and recommendations to the Medical Executive Committee in time for it to consider the report at its regularly scheduled meeting before the expiration of the applicant's appointment period. Where non reappointment, non-promotion of an eligible current appointee, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report. The Chairperson of the Medical Staff Credentials Committee shall be available to the Medical Executive Committee or to the Board, or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

ARTICLE VI - PART H:

Section 5. Medical Executive Committee Procedure:

- (a) The Medical Executive Committee shall transmit its written reports and recommendations concerning the reappointment, clinical privileges and, where applicable, change in staff category, of each person currently holding a Medical Staff appointment, to the Board, through the Chief Executive Officer, in time for the Board to consider reappointments at its next scheduled meeting in each reappointment period. Where non-reappointment, or non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff appointee has received a copy of the report and has exercised or has been deemed to have waived the right to request a hearing as provided in the Medical
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- Staff Bylaws. The Chairperson of the Medical Executive Committee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendations.
- (b) When the Medical Executive Committee has determined to make a recommendation contrary to the recommendation of the Medical Staff Credentials Committee, the Medical Executive Committee shall either:
- (1) remand the matter to the Medical Staff Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Executive Committee, prior to the Medical Executive Committee's final recommendation; or
 - (2) set forth in its report and recommendation to the Board the specific reasons for the Medical Executive Committee's disagreement with the Medical Staff Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or the Medical Staff Credentials Committee's report. This report will be presented to the applicant before it is forwarded to the Board.
- (c) If a recommendation is made by the Medical Executive Committee concerning reappointment that would entitle the applicant to a hearing pursuant to the Medical Staff Bylaws, the Chief Executive Officer shall promptly notify the individual of the recommendation in accordance with the Medical Staff Bylaws. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Bylaws, after which the Board shall be given the committee's final recommendation and shall act on it.

ARTICLE VI - PART I: PROCEDURE FOR REQUESTING A CHANGE IN CLINICAL PRIVILEGES

Section 1. Application for Additional Clinical Privileges:

Whenever, during the term of an appointment to the Medical Staff, an individual desires additional clinical privileges, he/she shall apply in writing to the Chief Executive Officer on the appropriate form. The application shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify additional privileges. This application will be transmitted by the Chief Executive Officer to the Medical Staff Credentials Committee and by it to the appropriate department chairperson. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application if the request is made at that time.

ARTICLE VI - PART I

Section 2. Factors to be Considered to Add Clinical Privileges:

Recommendations for an addition to clinical privileges made to the Board shall be based upon:

- (a) relevant recent training;
 - (b) observation of patient care provided;
 - (c) review of records of patients treated in this or other hospitals;
 - (d) results of hospital's quality measurement and improvement activities; and
 - (e) other reasonable indicators of the individual's continuing qualifications for the privileges in question. The recommendation for such additional privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary or desirable by the Medical Staff Credentials Committee.
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ARTICLE VI - PART I*Section 3. Deleting Clinical Privileges:*

Whenever, during the term of an appointment to the Medical Staff, an individual desires to delete a clinical privilege(s), he/she shall notify in writing the Chief Executive Officer. This request will be transmitted by the Chief Executive Officer to the Department Chairperson. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

ARTICLE VI - PART I*Section 4. Expedited Credentialing And Privileging:*

An expedited process for appointment/reappointment to the Medical Staff and when granting privileges may be used when specific criteria are met. Applications are processed through the Department Chair, Medical Staff Credentials Committee and the Medical Executive Committee. Expedited credentialing and privileging may be conducted and approved by the Board of Directors Credentials Committee with ratification by the Board of Directors at their next meeting.

- (a) An applicant is ineligible for the expedited process if any of the following has occurred:
 1. The applicant submits an incomplete application; or
 2. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
 - (b) The applicant may be ineligible for the expedited process if any of the following have occurred; however, these situations will be evaluated on a case-by-case basis:
 1. There is a current challenge or previously successful challenge to licensure or registration;
 2. The applicant has received an involuntary termination of Medical Staff membership at another organization;
 3. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
 4. The hospital determines that there has been either an unusual pattern of, or excessive number of, professional liability actions resulting in a final judgment against the applicant.
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ARTICLE VII

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE VII - PART A:

PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

Section 1. Grounds for Action:

Whenever, on the basis of information and belief, the President of the Medical Staff or the departmental chairperson or if unavailable, designees or vice chairpersons of a clinical department, and the Chief Executive Officer has cause to question:

- (a) the clinical competence of any Medical Staff appointee;
- (b) the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
- (c) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the hospital or its Board or Medical Staff, including, but not limited to the hospital's performance improvement, risk management, and utilization review programs; or
- (d) the professional cooperation of a Medical Staff appointee with the hospital staff in providing quality and orderly patient care.

A written request for an investigation of the matter shall be addressed to the Medical Staff Credentials Committee making specific reference to the activity or conduct which gave rise to the request. The Chairperson of the Medical Staff Credentials Committee shall promptly notify the Medical Executive Committee in writing of all requests for action regarding an individual received by the Medical Staff Credentials Committee and keep the Chief Executive Officer and Medical Executive Committee fully informed of all action taken in connection therewith.

ARTICLE VII - PART A:

Section 2. Investigative Procedure:

The Medical Staff Credentials Committee shall meet as soon after receiving the request as practicable and if, in the opinion of the Medical Staff Credentials Committee:

- (a) the request for investigation contains information sufficient to warrant a recommendation, the Medical Staff Credentials Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the appointee; or
- (b) the request for investigation does not at that point contain information sufficient to warrant a recommendation, the Medical Staff Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or, if it is deemed necessary, appoint an Investigating Committee.
 - (1) This Investigating Committee shall consist of up to three persons, at least two of whom shall be physicians, and any of whom may or may not hold appointments to the Medical Staff. This committee shall not include associates, or relatives of the affected individual, or those in direct economic competition with the affected individual.
 - (2) The Medical Staff Credentials Committee, its subcommittee or the Investigating Committee, if used, shall have available to them the full resources of the Medical Staff and the hospital to aid in their work, as well as the authority to use outside

consultants as required. The committee may also require a physical and mental examination of the appointee by a physician or physicians satisfactory to the committee and shall require that the results of such examination be made available for the committee's consideration.

- (3) The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Investigating Committee before it makes its report. The individual shall be informed in advance of the meeting of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Subcommittee or the Investigating Committee and included with its report to the Medical Staff Credentials Committee.
- (4) If a subcommittee or Investigating Committee is used, the Medical Staff Credentials Committee may accept, modify or reject the recommendation it receives from that committee.

ARTICLE VII - PART A:

Section 3. Suspension of Privileges:

At any time during the investigation the Medical Staff Credentials Committee, with the approval of the President of the Medical Staff and the Chief Executive Officer, may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall remain in effect during the investigation only, shall not indicate the validity of the charges and shall remain in force, without appeal, during the course of the investigation with an automatic review at least every seven days. If such a suspension is placed into effect, the investigation shall be completed within 30 days of the suspension or reasons for the delay shall be transmitted to the Medical Executive Committee which shall promptly recommend to the Board whether the suspension should be lifted.

ARTICLE VII - PART A:

Section 4. Procedure Thereafter:

- (a) In acting after the investigation, the Medical Staff Credentials Committee may recommend to the Medical Executive Committee the following:
 - (1) recommend that no action is justified;
 - (2) issue a written warning;
 - (3) issue a letter of reprimand;
 - (4) impose terms of probation;
 - (5) impose a requirement for consultation;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of staff appointment; or
 - (9) make such other recommendations as it deems necessary or appropriate.
- (b) Any recommendation by the Medical Executive Committee that would entitle the affected individual to the procedural rights provided in these bylaws shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has been deemed to have waived the right to a hearing as provided in these bylaws. At that time, the Chief Executive

- Officer shall forward the recommendation of the Medical Executive Committee, together with all supporting documentation to the Board. The Chairperson of the Medical Executive Committee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.
- (c) When the Medical Executive Committee has determined to make a recommendation contrary to the recommendation of the Medical Staff Credentials Committee, the Medical Executive Committee shall either:
- (1) remand the matter to the Medical Staff Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Executive Committee, prior to the Medical Executive Committee's final recommendation; or
 - (2) set forth in its report and recommendation to the Board the specific reasons for the Medical Executive Committee's disagreement with the Medical Staff Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or the Medical Staff Credentials Committee's report.
- (d) In the event the Board determines to consider modification of the action of the Medical Executive Committee and such modification would entitle the individual to a hearing in accordance with these bylaws, it shall so notify the affected individual, through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights so provided.

ARTICLE VII - PART B: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1. Grounds for Summary Suspension:

- (a) The President of the Medical Staff, the Chief Executive Officer or designee, and either the Chairperson of a clinical department or the Chairperson of the Medical Staff Credentials Committee, shall have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. If time permits, the individual exercising such authority should consult with one or more of these authorized individuals. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.
- (b) Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing by the Chief Executive Officer, to the President of the Medical Staff, and the Chairperson of the Medical Staff Credentials Committee, and shall remain in effect unless or until modified by the President of the Medical Staff, and the Chief Executive Officer or the Board. Such suspension may be reviewed every seven days at the request of the Medical Staff member and shall automatically be reviewed three days following the suspension.

ARTICLE VII - PART B:

Section 2. Credentials Committee Procedure:

Any person who exercises authority under Section 1 of this Part to summarily suspend clinical privileges shall immediately report this action to the Chairperson of the Medical Staff Credentials Committee to take further action in the matter. An investigation of the matter resulting in summary suspension shall be completed within 30 days of the suspension or reasons for the delay shall be transmitted to the Medical Executive Committee which shall promptly recommend to the Board whether the suspension should be lifted. At that point the Medical Staff Credentials Committee shall take such further action as is required in the manner specified

under Part C of this Article. The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the Chief Executive Officer, or until the matter that required the suspension is finally resolved.

ARTICLE VII - PART B:

Section 3. Care of Suspended Individual's Patients:

Immediately upon the imposition of a summary suspension, the appropriate department chairperson or, in his/her absence, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered in the selection of a substitute. It shall be the duty of the President of the Medical Staff and the department chairperson to cooperate with the Chief Executive Officer in enforcing all suspensions.

ARTICLE VII - PART C: OTHER ACTIONS

Section 1. Failure to Complete Medical Records:

The elective and emergency admitting clinical privileges of any individual shall be voluntarily relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after notification by the medical records department of such delinquency, unless the Medical Staff appointee is without fault. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent.

ARTICLE VII - PART C:

Section 2. Action by State Licensing Agency:

Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic suspension of all hospital clinical privileges as of that date, until the matter is resolved and the license restored. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly voluntarily restricted.

ARTICLE VII - PART C:

Section 3. Failure to be Adequately Insured:

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges that would be affected shall be automatically suspended or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

ARTICLE VII - PART C:

Section 4. Failure to Attend Meetings or Satisfy Continuing Education Requirements:

CME activities must be sponsored by an organization accredited for continuing medical education, and be designed as AMA Category I education by that organization. Proof of attendance at CME courses will be either a course certification form or a letter from the sponsor of the event stating that the physician attended the course. Failure to attend required meetings or failure to complete mandated continuing education requirements shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically consid-

ered by the Medical Staff Credentials Committee when making its recommendations for reappointment and by the Board when making its final decisions.

ARTICLE VII - PART C:

Section 5. Procedure for Leave of Absence:

- (a) Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence for a definitely stated period of time. Individuals on leave of absence are not exempt from the reappointment process and must reapply upon return if necessary.
- (b) Requests for leaves of absence shall be made to the chairperson of the department in which the individual applying for leave holds clinical privileges, and shall state the beginning and ending dates of the requested leave. The department chairperson shall transmit the request together with a recommendation to the Medical Staff Credentials Committee which shall make a report and a recommendation and transmit it to the Medical Executive Committee for action by the Board.
- (c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Chief Executive Officer summarizing his/her professional activities during the leave of absence. The individual shall also provide such other information as may be requested by the hospital at that time.
- (d) Reinstatement may be recommended by the Medical Staff Credentials and Medical Executive Committees either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

ARTICLE VII - PART D: CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this Article shall be treated as confidential. In addition, reports of actions taken pursuant to these bylaws shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

ARTICLE VII - PART E: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these bylaws are deemed to be protected by all then current peer review confidentiality legislation, whether State or Federal. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these bylaws shall be considered to be acting on behalf of the hospital and its Board when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986 or any amendments thereto after 1986.

ARTICLE VIII HEARING AND APPEAL PROCEDURES

ARTICLE VIII - PART A: INITIATION OF HEARING

An individual holding a Medical Staff appointment or applying for such appointment shall be entitled to a hearing whenever a recommendation unfavorable to him/her has been made by the Medical Executive Committee regarding those matters enumerated in Part B, Section 2 of this Article. The affected individual shall also be entitled to a hearing, before the Board enters a final decision, in the event the Board should determine, without a similar recommendation from the Medical Executive Committee, to take action set forth in Part B, Section 2 of this Article. The purpose of the hearing shall be to recommend a course of action to those acting for the hospital corporation, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out. Accordingly, the hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these bylaws.

ARTICLE VIII - PART B: THE HEARING

Section 1. Notice of Recommendation:

- (a) When a recommendation is made which, according to these bylaws entitles an individual to a hearing prior to a final decision of the Board on that recommendation, the affected individual shall promptly be given notice by the Chief Executive Officer, in writing, return receipt requested. This notice shall contain:
 - (1) a statement of the recommendation made and the general reasons for it;
 - (2) notice that the individual has the right to request a hearing on the recommendation within 30 days of this receipt of the notice; and
 - (3) a summary of the rights in the hearing as provided for in these bylaws.
- (b) Such individual shall have 30 days following the date of the receipt of such notice within which to request a hearing by the Hearing Panel hereinafter referred to. Said request shall be made by written notice to the Chief Executive Officer. In the event the affected individual does not request a hearing within the time and in the manner hereinabove set forth, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

ARTICLE VIII - PART B:

Section 2. Grounds for Hearing:

The following recommendations or actions constitute grounds for a hearing:

- (a) denial of initial Medical Staff appointment;
 - (b) denial of requested advancement in Medical Staff category;
 - (c) denial of Medical Staff reappointment;
 - (d) revocation of Medical Staff appointment;
 - (e) denial of requested initial clinical privileges;
 - (f) denial of requested increased clinical privileges;
 - (g) decrease of clinical privileges;
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- (h) suspension of total clinical privileges;
- (i) imposition of mandatory concurring consultation requirement.

ARTICLE VIII - PART B:

Section 3. Unappealable Actions:

These bylaws do not provide any circumstances of unappealable action when any change in clinical privileges of a staff member is involuntarily forced upon him/her.

ARTICLE VIII - PART B:

Section 4. Notice of Hearing and Statement of Reasons:

The Chief Executive Officer shall schedule the hearing and shall give notice of its time, place and date, in writing, return receipt requested, to the person who requested the hearing. The notice shall also include a proposed list of witnesses who will give testimony or evidence in support of the Medical Executive Committee or the Board at the hearing. The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties. This notice shall contain a statement of the specific reasons for the recommendation as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and his/her counsel have sufficient time to study this additional information and rebut it.

ARTICLE VIII - PART B:

Section 5. List of Witnesses:

A written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of the Medical Executive Committee or the Board at the hearing, shall be given with the notice of hearing. The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten days after receiving notice of the hearing. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

ARTICLE VIII - PART B:

Section 6. Hearing Panel:

When a hearing is requested, a hearing panel shall be appointed which shall be composed of not less than three members. If the hearing is the result of action by the Medical Executive Committee, the President of the Medical Staff in consultation with the Chief Executive Officer shall appoint panel members who are Medical Staff appointees who have not actively participated in consideration of the matter involved at any previous level. If the hearing is the result of original action by the Board, the chairperson of the Board in consultation with the Chief Executive Officer and the President of the Medical Staff shall appoint panel members who are Medical Staff appointees who have not actively participated in the consideration of the matter involved at any previous level, Board members or other individuals.

The Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the

affected person. Such appointment shall include designation of the chairperson. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

ARTICLE VIII - PART B:

Section 7. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

ARTICLE VIII - PART B:

Section 8. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in these bylaws may be requested by anyone but shall be permitted only by the Hearing Panel, its chairperson or the entity which appointed the Hearing Panel on a showing of good cause.

ARTICLE VIII - PART B:

Section 9. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the Chief Executive Officer.

ARTICLE VIII - PART B:

Section 10. Disposition of Hearing Panel Report:

Upon its receipt, the Chief Executive Officer shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Board for further action. The Chief Executive Officer shall also send a copy of the report and recommendation, return receipt requested, to the individual who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Medical Staff Credentials Committee, a copy of the report of the Hearing Panel shall be delivered by the Chief Executive Officer to the committee for informational purposes.

ARTICLE VIII - PART C: HEARING PROCEDURE

Section 1. Representation:

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He/She shall inform the Chief Executive Officer in writing of the name of that person at least ten days prior to the date of the hearing. The Chief Executive Officer shall appoint a person, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine and cross-examine witnesses at the hearing.

ARTICLE VIII - PART C:

Section 2. Presiding Officer:

- (a) The Chief Executive Officer shall appoint an attorney to act as an advisor to the Hearing Panel who may also serve as presiding officer without vote. If no other person is
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- appointed as presiding officer, the Chairperson of the Hearing Panel shall be the presiding officer and shall be entitled to one vote.
- (b) The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. The presiding officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he/she may be advised by legal counsel to the hospital. In all instances the presiding officer shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board.

ARTICLE VIII - PART C:

Section 3. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

ARTICLE VIII - PART C:

Section 4. Rights of Both Sides:

At a hearing both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. If the person requesting the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross examination.

ARTICLE VIII - PART C:

Section 5. Admissibility of Evidence:

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

ARTICLE VIII - PART C:

Section 6. Official Notice:

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party

shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

ARTICLE VIII - PART C:

Section 7. Basis of Decision:

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

- (a) oral testimony of witnesses;
- (b) memorandum of points and authorities presented in connection with the hearing;
- (c) any information regarding the person who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
- (d) any and all applications, references, and accompanying documents;
- (e) all officially noticed matters;
- (f) any other evidence that has been admitted.

ARTICLE VIII - PART C:

Section 8. Burden of Proof:

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

- (a) The Board or the Medical Executive Committee, depending on whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in his/her support.
- (b) After all the evidence has been submitted by both sides, the Hearing Panel shall make a decision based on the facts introduced before the panel.

ARTICLE VIII - PART C:

Section 9. Attendance by Panel Members:

The vote shall be by majority of those appointed to the Hearing Panel. A panel member shall have been present at all times throughout the hearing in order to be eligible to vote.

ARTICLE VIII - PART C:

Section 10. Adjournment and Conclusion:

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

ARTICLE VIII - PART D: APPEAL

Section 1. Time for Appeal:

Within 10 days after the affected individual is notified of an adverse recommendation from the Hearing Panel, or an adverse recommendation from a Board committee modifying a recommendation of a Hearing Panel which was favorable to the affected individual, he/she may request an appellate review. The request shall be in writing, and shall be delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within 10 days as provided herein, the

affected individual shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

ARTICLE VIII - PART D:

Section 2. Grounds for Appeal:

The grounds for appeal from an adverse recommendation shall be that:

- (a) there was substantial failure on the part of the Hearing Panel or Board committee, whichever recommendation is the subject of the appellate review, to comply with the hospital or Medical Staff bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or
- (b) the recommendations of the Hearing Panel or Board committee were made arbitrarily, capriciously or with prejudice; or
- (c) the recommendations of the Hearing Panel or Board committee were not supported by the evidence.

ARTICLE VIII - PART D:

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, within ten days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than 20 days, nor more than 40 days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Board for good cause.

ARTICLE VIII - PART D:

Section 4. Nature of Appellate Review:

- (a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the hospital, or any combination of the same, to consider the record upon which the recommendation before it was made.
 - (b) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he/she was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel.
 - (c) Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board.
 - (d) The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.
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ARTICLE VIII - PART D:

Section 5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the President of the Medical Staff, in person or by certified mail.

ARTICLE VIII - PART D:

Section 6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 30 days in duration except as the parties may otherwise stipulate.

ARTICLE VIII - PART D:

Section 7. Right to One Appeal Only:

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff to an applicant or revoke or terminate the Medical Staff appointment and clinical privileges of a current appointee, that individual may not again apply for Medical Staff appointment or clinical privileges at this hospital unless the Board provides otherwise. However, nothing in this policy shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of an appointee to apply for reappointment and clinical privileges after the expiration of five years from the date of such Board decision unless the Board provides otherwise in its written decision.

ARTICLE IX MEDICAL ASSOCIATES

ARTICLE IX - PART A: MEDICAL ASSOCIATES

Section 1. Qualifications:

- (a) Classes of independent health care professionals other than physicians and dentists, who are approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies and who desire to provide professional services in the hospital, are eligible to practice as Medical Associates.
- (b) Each such individual shall file an application on a form provided by the hospital. Each applicant shall be evaluated by the Medical Staff Credentials Committee, which shall recommend the scope of practice that the applicant shall be permitted to exercise at the hospital either in general or limited to a particular case.
- (c) Each such individual must provide evidence of current, valid professional liability insurance coverage in such terms and in amounts satisfactory to the hospital.

ARTICLE IX - PART A:

Section 2. Conditions of Practice:

- (a) Medical Associates shall practice at the discretion of the Board, and thus may be terminated at will by the Board and shall not be covered by the due process provisions of this policy or the corporate bylaws. However, a Medical Associate shall have the right to appear personally before the Medical Staff Credentials Committee to discuss the clinical privileges recommended by that Committee before that recommendation is transmitted to the Medical Executive Committee and the Board.
 - (b) Medical Associates shall be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice or clinical privileges specifically granted. They shall be located within the geographic service area of the hospital, close enough to fulfill their responsibilities, and to provide timely care for their patients in the hospital.
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ARTICLE X

RULES AND REGULATIONS OF THE MEDICAL STAFF

- (a) Medical Staff rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these bylaws, shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the bylaws.

 - (b) Rules and Regulations may be adopted, amended, repealed or added by the Medical Staff provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board.
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ARTICLE XI AMENDMENTS

- (a) Any proposed amendments of these bylaws shall, as a matter of procedure, be referred to the Medical Executive Committee. The Medical Executive Committee may appoint a Bylaws Committee to consider the amendments and make a recommendation. The Medical Executive Committee shall report on them either favorably or unfavorably to the Medical Staff. A copy of the proposed changes and a ballot will then be mailed to all voting members of the Medical Staff. The ballot must be returned to the Medical Staff Office within thirty days. To be adopted, an amendment must receive 2/3 of the votes cast by the voting staff. Amendments so adopted shall be effective when approved by the Board.

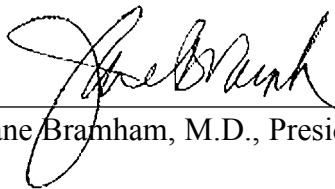
 - (b) The Medical Executive Committee shall have the power to adopt such amendments to the bylaws as are, in the committee's judgment, merely technical in nature or are required by laws or accrediting agencies, modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar, numbering or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff within 90 days of adoption by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. Immediately upon adoption, such amendments shall be sent to the Chief Executive Officer and posted on the Medical Staff bulletin board for 14 days.

 - (c) Neither the Medical Staff or the Hospital shall unilaterally amend these bylaws.
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ARTICLE XII ADOPTION

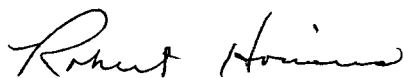
- (a) These bylaws shall be adopted by a majority vote of the Medical Staff and shall become effective upon approval of the Board, superseding and replacing any and all previous Medical Staff bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the hospital shall be taken under and pursuant to the requirements of these bylaws.
- (b) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these bylaws, until such time as they are amended in accordance with the terms of these bylaws.

Adopted this 7th day of April, 2006 by the Medical Staff of The Medical Center:



Jane Bramham, M.D., President of the Medical Staff

Approved this 16th day of May, 2006 by the Board of The Medical Center:



Robert Hovious, Chairperson of the Board

RULES AND REGULATIONS

1. The schedule of the regular meetings of the Staff will be determined at the annual meeting of the Medical Staff.
 2. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper written consent. All autopsies shall be performed by the hospital pathologist or designee.
 3. Each patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff.
 4. Standing orders shall be signed and dated by the attending physician and a reproduction of these orders shall be placed in appropriate charts and signed by the physician.
 5. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a licensed nurse, licensed pharmacist, certified or registered respiratory therapist, licensed physical therapist or registered dietician as appropriate and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his or her next visit, the attending physician shall sign such orders.
 6. Each member of the Medical Staff not resident in the immediate vicinity or not working in the vicinity shall name a Member of the Medical Staff, who is a resident in the city, who may be called to attend patients in an emergency. In case of failure to name such associate, that physician's departmental chairperson shall have the authority to call any member of the Staff should he/she consider it necessary.
 7. Physicians are subject to the hospital approved Emergency Management Plan.
 8. No patient shall be admitted to the hospital until a provisional diagnosis has been stated and the consent of the Chief Executive Officer or his delegate secured.
 9. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray, and other; provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress note, follow-up, a narrative discharge summary and autopsy when available. Records of patients receiving special treatments such as Electroconvulsive therapy and restraints shall include documentation of such. No medical record shall be filed until it is complete, except on the order of the Medical Executive Committee.
 10. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.
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11. History and Physicals:

(a) Inpatient History and Physicals:

1. History and physical examination shall be recorded within 24 hours of admission. Details of the present illness shall include:
 - Chief Complaint
 - Present Illness
 - Current Medications
 - Past Medical History
 - Social History
 - Psychosocial History
 - Family History
 - Review of Systems
 - Physical Exam
 - Impression
 - Plan of Care
2. If a complete history and physical (see #1) has been recorded in the physician's office, or the patient has been readmitted for the same or similar problem within thirty (30) days prior to the patient's admission, a legible copy of the H&P may be used in the patient's medical record providing a reassessment by the examining physician is noted, authenticated and dated within 24 hours of the admission.
3. Consultation reports may be substituted for the history and physical if completed within 24 hours of admission and all components of a history and physical (as listed in #1) are met. The consultation report will require the attending physician's co-signature to indicate agreement.

(b) Outpatient History and Physicals:

1. A pertinent history and physical to include at least relevant history of illness or injury and physical findings shall be recorded in the patient's record before undergoing any diagnostic or therapeutic invasive procedure* which is to be performed under conscious sedation, regional block, epidural, general anesthesia or monitored anesthesia care (MAC). Ambulatory operative/invasive procedures performed in the operating suite require a complete H&P or, in cases of emergency surgery, a brief pertinent note. This must be on the patient's record or available via electronic version prior to the procedure. Ambulatory operative invasive procedures not performed in the operating suite require a complete H&P or a brief H&P (Handwritten History and Physical Form). An H&P performed within thirty (30) days prior to the procedure may be used providing a reassessment by the examining physician is noted, authenticated, and dated immediately prior to procedure. The brief H&P shall include the following:
 - Preoperative Diagnosis
 - Significant past medical history
 - Allergies
 - Pertinent Physical Examination to include heart/lungs
 - Plan for Anesthesia
 - Treatment and Progress
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*An invasive procedure is a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

2. When a transcribed history and physical examination, or a handwritten H&P form is not present on the chart before an operation or invasive procedure, the procedure shall be canceled unless the attending practitioner has stated in writing that such delay would be detrimental to the patient.

(c) Behavioral Health History and Physicals:

1. A complete history and physical examination for patients in the outpatient Psychiatric Partial Hospitalization Program shall be written or dictated within 48 hours of admission to the Program. A documented history and physical within 60 days prior to admission is acceptable.

(d) Long Term Care History and Physicals:

1. A complete history and physical examination for patients in the Long Term Care Facility must be written or dictated within 72 hours of admission to the facility, except when an examination was performed within 5 (five) days before admission and the findings were recorded in the medical record on admission.

12. All records are the property of the hospital and shall not be taken away without subpoena, court order or statute. In case of re-admission of a patient, all previous records shall be available for the use of the attending physician.
 13. Free access to all medical records of all patients shall be afforded to Staff physicians in good standing for bonafide study and research, consistent with preserving the privacy of personal information concerning the individual patients. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
 14. A surgical procedure shall be performed only on informed consent of the patient or his/her legal representative, except in emergencies.
 15. All medical procedures/surgical procedures performed shall be fully described by the operating surgeon in the record. All operative reports are to be dictated or written immediately after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note shall be entered immediately.
 16. All tissue or foreign bodies removed at the operation shall be sent to the hospital pathologist who shall make such examination considered necessary to arrive at a pathological diagnosis and a report shall be signed.
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Exception to this general rule are limited and at the discretion of the operating surgeon. Notation of the exception and/or a description of the specimen should be included in the medical record by the surgeon. The specimens forming these exceptions include the following:

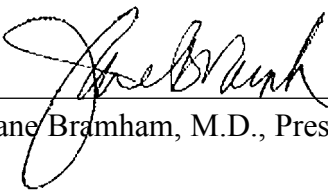
- a. Teeth, provided the number of teeth and fragments is included in the medical record by the operating physician.
 - b. Foreign body, e.g., bullet, that for legal reasons is given directly to the custody of law enforcement representatives.
 - c. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.
 - d. Specimens known to rarely ever show pathologic changes and removal of which is highly visible post-operatively, such as prepuce from circumcision of a newborn infant.
17. Surgeons must be in the operating room and ready to commence operating at the time scheduled and in no case will the operating room be held longer than 15 minutes after the time scheduled for except for good cause.
18. The operating surgeon shall have a qualified assistant at all major medical procedures/surgical procedures.
19. Consultations:
- a. Indications: Except in an emergency, consultation with another qualified physician should be considered in cases in which, according to the judgement of the physician:
 1. The patient is not a good risk for operation or treatment.
 2. The diagnosis is obscure.
 3. There is doubt as to the best therapeutic measures to be utilized.
 4. The patient requires special care services, treatments or procedures for which the physician does not hold privileges.
 - b. Consultant: A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of an individual's training, experience and competence.
 - c. Essentials of a Consultation: A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.
 - d. Responsibility for Requesting Consultation: The patient's physician is responsible for requesting consultations when indicated. It is the duty of the hospital staff through its President of the Medical Staff and Medical Executive Committee to make certain that Members of the Staff do not fail in the matter of calling consultations as needed. Physicians seeking consultations should identify the degree of participation of the consultant in the care of the patient.
20. Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-official Drugs, with the exception of drugs for bonafide clinical investigation or as determined by the Institutional Review Board. Exceptions to this rule shall be well justified. The hospital pharmacist may use chemically identical drugs interchangeably unless otherwise ordered by the attending physician.
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21. All dental surgery patients must have a history and physical done by a medical doctor with the dental portion done by the dentist, which shall include a detailed description of the physical findings of the oral cavity prior to surgery. Oral maxillo-facial surgeons who are privileged may perform their own history and physical in cases that do not involve any medical problem. Any abnormalities shall be reported. Care of any medical problems that may be present or may arise during hospitalization shall be supervised by a medical doctor. There shall be medical supervision of the medical aspects of the case throughout. Procedures done by an oral maxillo facial surgeon are to include only management of fractures of the mandible and maxilla, impacted teeth, cysts and benign tumors of dental origin. Upon proof of the presence of malignant lesions, the case should be referred to a member of the surgical staff. If definitive treatment is to be given in this hospital, then the oral maxillo-facial surgeon should be encouraged to participate in that treatment. All surgical procedures performed by a dentist shall be under the supervision of the Chairperson of the Department of Surgery.
 22. The parliamentary procedure of Medical Staff meetings shall be the most current Roberts Rules of Order.
 23. All charts on discharged patients should be completed within 30 days. The Health Information Management Team, with the approval of the Medical Executive Committee, shall take such measures as necessary to insure compliance with this. All physicians shall be advised of suspension policies.
 24. All laboratory procedures upon hospitalized patients shall be performed through the hospital laboratory.
 25. Every Associate/Active Staff Member will take call in their respective specialty for a period of not less than 20 years. Any exception must be presented to the Medical Executive Committee for review on a case by case basis.
 26. Those staff physicians who fail to provide coverage shall be subject to disciplinary actions, including possible suspension of privileges. Each Department shall determine appropriate coverage by establishing policy with approval of the Medical Executive Committee.
 27. These Rules and Regulations shall be reviewed periodically by the Bylaws Committee of the Medical Staff.
 28. All documents maintained by the hospital as a permanent record of credentialing, disciplinary investigations, or peer review proceedings regarding an individual physician shall be made available for inspection upon the written request of the individual physician, except that certain information may be withheld as required by patient rights of privacy or other recognized rules of confidentiality or privilege.

Unless specifically addressed in the Bylaws, any focused monitoring involving a specific physician shall be reported to the physician.
 29. All electrocardiographic tracings shall be interpreted and reported by a duly qualified physician. Such qualifications shall be the responsibility of the Medical Staff Credentials Committee.
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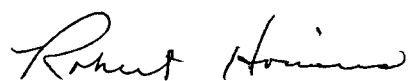
30. Applicants in specialties or subspecialties will provide evidence of appropriate training and eligibility for certification by an approved board in that specialty or subspecialty or, if not eligible for certification, possess equivalent qualifications.
31. Progress notes shall be written daily by either the attending physician or another physician involved in the care of the patient.
32. All patients presenting to the Emergency Department shall receive a medical screening examination from a physician except for obstetrical patients who will be taken to Labor and Delivery where they will be screened by an obstetrical nurse. Patients presenting to the Emergency Department of the Scottsville facility will receive a medical screening examination from a physician or a registered nurse during those periods when a physician is not on duty in the Department.

Adopted this 7th day of April, 2006 by the Medical Staff of The Medical Center:



Jane Bramham, M.D., President of the Medical Staff

Approved this 16th day of May, 2006 by the Board of The Medical Center:



Robert Hovious, Chairperson of the Board

