ST. JOSEPH'S HOSPITAL

MEDICAL STAFF BYLAWS

July 11, 2019

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MEDICAL STAFF BYLAWS

The Medical Staff Bylaws shall be applicable to all Medical Staff appointees and, as appropriate, to other individuals who have been granted clinical privileges or a scope of practice, and shall be an integral part of the Medical Staff Bylaws, subject to the amendment provisions contained in each Part.

TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital administration, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

PREAMBLE

WHEREAS, St. Joseph's Hospital of the Hospital Sisters of the Third Order of St. Francis (the "Hospital") is a non-stock corporation organized under the laws of the State of Wisconsin and is a Catholic institution of the Diocese of LaCrosse; and

WHEREAS, its purpose is to serve as an acute care hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Directors, and that the cooperative efforts of the Medical Staff, the Hospital Chief Executive Officer and the Board of Directors are necessary to fulfill the obligations of the Hospital to its patients;

THEREFORE, pursuant to the authority delegated at Article X, Section 1 of the Hospital Bylaws of St. Joseph's Hospital the physicians practicing in St. Joseph's Hospital are organized into a Medical Staff and will operate as such in conformity with these Bylaws.

ARTICLE I: DEFINITIONS

1. "Allied Health Professional" means an individual, other than a physician, dentist, or podiatrist, whose patient care activities require that his or her authority to perform patient care services or to exercise specific clinical privileges or a scope of practice be processed through Medical Staff channels or with involvement of Medical Staff representatives.

2. "Appointee" means any physician, dentist and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board of Directors to practice at the Hospital.

3. "Authorized representatives" means any persons who have responsibility for obtaining or evaluating credentials, acting upon applications, or conducting professional review activity, including Board of Directors members, Medical Staff appointees or committee members, Hospital employees, consultants and legal counsel.

4. “Board Certification” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the Royal College of Physicians and Surgeons of Canada, or the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant’s area of clinical practice.

5. "Board of Directors" ("Board") means the Board of Directors of the Hospital which has the overall responsibility for the conduct of the Hospital, including the Medical Staff.

6. "Chairperson" means the Medical Staff member duly appointed or elected in accordance with these Bylaws to serve as head of a specific Department or Committee hereunder.

7. “Chief Executive Officer” or “CEO” means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.

8. “Chief Medical Information Officer” or “CMIO” means the individual appointed by the Hospital to be generally responsible for the health informatics platform and management of medical information in collaboration with the Medical Staff.

9. “Chief Physician Executive” or “CPE” means the individual appointed by the Hospital to act as the Chief Physician Executive of the Hospital, in cooperation with the President of the Medical Staff.

10. “Clinical Privileges” or “privileges” means the authorization granted by the Board to an applicant, a Medical Staff appointee, licensed independent professional, or advanced dependent professional to render specific patient care services in the Hospital within defined limits.

11. “Corrective Action” means the termination of medical staff membership or a restriction, reduction, modification, or termination of medical staff privileges for reasons of clinical incompetence or unprofessional conduct.

12. “CVO” means the Credentials Verification Office.

13. “Days” means calendar days.
14. "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").

15. "Department" means one of the clinical areas of practice referred to in Article VI of these Bylaws.

16. “Emergency Call” means the responsibility to accept unassigned patients in accordance with the on-call policy.

17. “EMR” means the electronic medical record.

18. “Ex Officio” means services a member of a body by virtue of an office or position held and, unless otherwise expressly provided in these bylaws, means without voting rights.

19. "Federal health program" means Medicare, Medicaid or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States Government.

20. “Good Standing” means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this Hospital and/or at any other health care facility or organization.

21. "Hospital" means St. Joseph's Hospital of the Hospital Sisters of the Third Order of St. Francis, Chippewa Falls, Wisconsin.

22. "Hospital Administration" means Chief Executive Officer or his or her designee, including the administrator on call.

23. "Hospital colleague" means an individual who would qualify as an "employee" under definitions of the same under Wisconsin law.

24. "Licensed Independent Professional" means an allied health professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.

25. “Locum Tenens” means a practitioner who has been granted temporary privileges for the sole purpose of holding the place of a Medical Staff member during a period of temporary unavailability.

26. "Medical Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Board of Directors.

27. "Medical Staff" means all physicians, dentists and podiatrists who are granted appointment and, when appropriate, privileged to treat patients at the Hospital.

28. “Medical Staff Leader” means any Medical Staff officer, department chairman, or committee chairman.

29. The "Medical Staff Year" shall be from July 1 through June 30.

30. "Member" means any physician, dentist and podiatrist who has been granted Medical Staff appointment by the Board to practice at the Hospital.

31. “Notice” means written communication by regular U.S. mail, e-mail, facsimile or Hospital mail, hand delivery, or posting.

32. “Organized Health Care Arrangement” means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

33. “Patient Contacts” may include admissions, consultations, procedures, responses to emergency call, evaluations, treatments or services performed in any facility operated by the Hospital or an affiliate, including outpatient facilities, or, alternatively, may be defined by the departments and approved by the Medical Executive Committee.

34. "Physicians" shall be interpreted to include both Doctors of Medicine ("M.D.s") and Doctors of Osteopathy ("D.O.s")

35. "Podiatrist" shall be interpreted to mean a Doctor of Podiatric Medicine ("D.P.M.").

36. “Prerogative” means a participatory privilege granted by virtue of staff category assignment, to a Medical Staff appointee and which may be exercised subject to the conditions impose by these Bylaws and other applicable bylaws documents and Medical Staff policies.

37. “Professional Review Action” means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of an appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

38. “Professional Review Activity” means an activity of a health care entity with respect to an individual practitioner to determine whether the practitioner may have clinical privileges or membership in the entity, to determine the scope or conditions of such privileges or membership, or to change or modify such privileges or membership.

39. “Professional Review Body” means the Board of the Hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

40. "Scope of Practice" means the authorization granted to an allied health professional to perform certain clinical activities, tasks and functions consistent with applicable state statutes and regulations and Medical staff rules and regulations, and policies.

41. “Self-government” means the duty of the Medical Staff officers, committees and departments, to initiate and carry out the functions delegated by the Board to fulfill the obligations provided for in these Bylaws.

42. “Special Notice” means written notice sent by certified mail, return receipt requested or overnight delivery service providing receipt. When calculating the time for giving special notice, Sundays and holidays shall not be counted.

43. “Sponsoring practitioner” means a member of the Medical Staff with clinical privileges, who has agreed to provide oversight for an allied health professional.

44. "Supervising Physician" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a dependent or advanced dependent professional and to accept full

responsibility for the actions of the dependent or advanced dependent professional while he or she is practicing in the Hospital.

45. "Supervision" means the supervision of (or collaboration with) a dependent or advanced dependent professional by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each dependent or advanced dependent professional is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

46. "Third parties" includes, but is not limited to, other hospitals, health care facilities/entities, government agencies, former employers, insurers, and managed care plans.

47. “Unassigned patient” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital.

48. "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or clinical privileges or scope of practice means a lapse in appointment, clinical privileges or scope of practice deemed to automatically occur as a result of stated conditions.

Words used in these Bylaws shall be read as the masculine, feminine or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to delimit or define the scope or affect of any provisions of these Bylaws.

ARTICLE II: PURPOSES

The purposes of this Medical Staff are:

1. to strive to provide care to all patients admitted to or treated in any of the facilities, departments or services of the Hospital regardless of race, creed, color, sex, national origin or ability to pay;

2. to delineate clinical privileges that each practitioner may exercise in the Hospital through an ongoing review and evaluation of each member or appointees performance in the Hospital; and

3. to provide a means whereby issues concerning the Medical Staff, and other affiliates or associates of the Staff and the Hospital may be discussed by the Medical Staff with the Board of Directors and the Chief Executive Officer.

ARTICLE III: GENERAL PROVISIONS

A. MEDICAL STAFF RESPONSIBILITIES SUMMARIZED

The responsibilities of the Medical Staff, to be fulfilled through the actions of its officers, departments and committees, shall include:

1. accountability for the quality and appropriateness of patient care rendered by all Medical Staff appointees and allied health professionals who are authorized to practice in the Hospital pursuant to the Hospital’s credentialing processes for initial appointment, reappointment, and for clinical privileges, continuing medical education programs for staff appointees and Hospital personnel

and students, utilization review program, and quality assessment/performance improvement activities, including, but not limited to, valid and reliable patient care audit procedures; and

2. assisting the Board and Hospital administration to identify community health needs and in setting appropriate institutional goals and implementation plans to meet those needs.

B. CONFIDENTIALITY AND PEER REVIEW PROTECTIONS

1. Confidentiality:

   Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

   a. when the disclosures are to another authorized member of the Medical Staff, the CEO, legal counsel or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities; or

   b. when disclosures are authorized by a Medical Staff or Hospital policy.

   Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

2. Peer Review Protections:

   a. All credentialing and peer review activities pursuant to these Bylaws and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with Wis. Stat. Ann. §146.37, §146.38 and other applicable Wisconsin law. Peer review can occur:

      1) at all standing and ad hoc Medical Staff and Hospital committees;

      2) at hearing panels;

      3) at the Board and its committee meetings;

      4) by any individual acting for or on behalf of any such entity, including but not limited to department Chairmen, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

      5) at all department meetings.

      All oral and written communication, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Wis. Stat. Ann. §146.38.

   b. All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. '11101 *et seq*.

C. CORPORATE COMPLIANCE

All Medical Staff appointees shall cooperate fully with the Corporate Compliance Policy of St. Joseph's Hospital and adhere to all laws, regulations and standards of conduct applicable to their activities at the Hospital, the practice of their profession, and their participation in any federal health program, as a condition of their continued appointment to the Medical Staff. In the event that any Medical Staff appointee knows or suspects that he or she or any director, officer, employee or other Medical Staff appointee has violated applicable laws or regulations, that appointee shall immediately report the matter to the CEO or the Corporate Responsibility Officer.

D. CONFLICT OF INTEREST

1. When performing a function outlined in these Bylaws or the Medical Staff Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

2. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable department or committee chair. The President of the Medical Staff or the applicable department chairman or committee chair shall make a final determination as to whether the provisions in this Article should be triggered.

3. The fact that a department chairman or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

4. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

E. INDEMNIFICATION WHEN PERFORMING CREDENTIALING AND PEER REVIEW FUNCTIONS

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairmen, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

All appointments and reappointments to the Medical Staff shall be for two year periods. The reappointments may be staggered so that approximately one half of the Medical Staff is considered for reappointment each year. All appointments to the Medical Staff shall be made by the Board and shall be

to one of the following categories of the Staff. All members 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/or Policy Manuals and as approved by the Board.

A. ACTIVE STAFF

1. Qualifications:

   The Active Staff shall consist of those physicians, dentists and podiatrists who:

   a. meet the qualifications for appointment as set forth in these Bylaws;

   b. are professionally based in the community served by the Hospital, close enough to provide timely and continuous care to their patients in the Hospital and to fulfill their staff responsibilities; and

   c. regularly attend, admit or are involved in the treatment or care of patients at the Hospital.

2. Responsibilities and Prerogatives:

   By accepting appointment to the Active Staff, each individual shall:

   a. agree to assume all the functions and duties of the Active Staff including specifically, and where appropriate, care for unassigned patients, coverage for emergency service care, consultation and teaching assignments, and participation in quality assessment and monitoring activities;

   b. exercise only those clinical privileges granted by the Board;

   c. attend Medical Staff , department, and committee meetings, as applicable;

   d. be entitled to vote on all matters presented at general and special meetings of the Medical Staff and the department and committees of which the appointee is a member;

   e. serve as needed chief of a department or chairperson of Medical Staff committees;

   f. serve as a Medical Staff officer provided they have been an Active Staff member for three (3) years;

   g. participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

   h. pay staff dues and assessments.

B. COURTESY STAFF

The Courtesy Staff shall consist of members qualified for Medical Staff appointment. Courtesy Staff members must have an Active Staff appointment at another licensed hospital. At each reappointment,

Courtesy Staff members must provide clinical performance information in such form as may be requested by the Hospital.

1. Responsibilities and Prerogatives:

   By accepting appointment to the Courtesy staff, each individual shall:

   a. agree to follow the individual's patients in the Hospital and to provide medical consultation upon request of an attending practitioner on the Medical Staff;

   b. exercise only those clinical privileges granted by the Board;

   c. have the right to attend Medical Staff , department, and committee meetings, as applicable;

   d. have the right to attend medical staff and Hospital educational programs;

   e. not be eligible to vote except when serving on a committee, or to hold Medical Staff Office or to serve as a department chairperson;

   f. participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

   g. pay staff dues and assessments.

C. CONSULTING STAFF

The Consulting Staff shall consist of members qualified for Medical Staff appointment who treat outpatients at the Hospital or who only serve as consultants. At each reappointment, Consulting Staff members must provide clinical performance information in such form as may be requested by the Hospital.

1. Responsibilities and Prerogatives:

   Consulting Staff appointees:

   a. shall participate in the peer review and performance improvement programs as requested and/or required by the Hospital;

   b. must provide consultation when requested by an attending Medical Staff appointee or the clinical department chairperson;

   c. must exercise only those clinical privileges granted by the Board;

   d. may attend meetings of the Medical Staff and applicable clinical department meetings, without vote, and applicable committee meetings, with vote;

   e. are not eligible to admit patients to the Hospital, but may treat patients if granted clinical privileges to do so;
   f. may not hold Medical Staff office or serve as clinical department chairperson;

g. are encouraged to communicate with hospitalists and/or other Active, Courtesy and Consulting Staff members about the care of any patients referred to them;

h. may petition the Medical Executive Committee to address a matter of concern which has not been adequately resolved via discussion with the hospitalist involved or chairperson of the Medicine Department. Such petition must be submitted in writing addressed to the President of the Medical Staff; and

i. shall pay dues and assessments.

D. COVERAGE STAFF

1. Qualifications:

The Coverage Staff shall consist of individuals of demonstrated competence qualified for Medical Staff appointment, who:

a. provide or are members of a coverage group which provides periodic coverage for a practitioner who is an Active Staff appointee in good standing;

b. have an appointment at another hospital or other clinical practice entity; and

c. provide, at reappointment, evidence of clinical performance (performance profile) at their primary hospital or clinical practice entity in such form as may be requested by the Hospital.

2. Responsibilities and Prerogatives:

Coverage Staff appointees:

a. shall assume all functions and responsibilities required to provide coverage for other members of their coverage group, including, where appropriate, care for service patients, emergency service care and consultations;

b. may attend and participate in Medical Staff and clinical department meetings, without vote;

c. may not hold office or serve as clinical department chairperson;

d. shall participate in the peer review and performance improvement programs as requested and/or required by the Hospital; and

e. shall pay dues and assessments.

E. AFFILIATE STAFF

1. Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

a. desire to be associated with, but who do not intend to establish a practice at this Hospital;
b. are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital; and

c. satisfy the qualifications for appointment set forth in these Bylaws.

2. Responsibilities and Prerogatives:

Affiliate Staff Members:

a. may attend meetings of the Medical Staff and applicable department (without vote);

b. may not hold office or serve as a department chair;

c. may be invited to serve on committees (with vote), including serving as committee chair;

d. may attend educational activities sponsored by the Medical Staff and the Hospital;

e. may refer patients to members of the Medical Staff for admission and care;

f. are encouraged to communicate directly with members about the care of any patients referred, as well as to visit any such patients;

g. may review the medical records and test results (via paper or electronic access) for any patients who are referred;

h. may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical record;

i. are not granted inpatient or outpatient clinical privileges and; therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

j. may refer patients to the Hospital's diagnostic facilities and order such tests;

k. are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

l. shall pay application fees, dues, and assessments.

The grant of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Governing Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

F. HONORARY STAFF

1. The Honorary Staff shall consist of members who are not active in the Hospital or who are honored by a meritorious position. These may be physicians who have retired from active hospital practice or physicians who are of outstanding reputation, not necessarily residing in the community.

2. Honorary members are not eligible to admit patients, to exercise clinical privileges in the Hospital, hold office, or to serve on standing Medical Staff committees. Honorary Staff members shall not pay dues and shall not be eligible to vote on Medical Staff matters.

ARTICLE V: STRUCTURE OF THE MEDICAL STAFF

A. GENERAL

1. Medical Staff Year:

   For the purpose of these bylaws the Medical Staff year commences on the 1st day of July and ends on the 30th day of June each year.

2. Dues:

   All persons appointed to the Medical Staff, except Honorary Staff appointees, shall pay annual staff dues as may be recommended by the Medical Executive Committee and approved by the Board from time to time. Signatories to this account shall be the President and the Secretary-Treasurer of the Medical Staff.

B. OFFICERS

1. Officers of the Medical Staff:

   The Officers of the Medical Staff shall be:

   - President
   - Vice President
   - Secretary/Treasurer

2. Qualifications of Officers:

   Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

   a. be appointed in good standing to the Active Staff and shall continue to do so during the term of their office. Medical Staff officers shall have served on the Active Staff for at least three years;

   b. have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

   c. be willing to faithfully discharge the duties and responsibilities of the position;

   d. have experience in a leadership position, or other involvement in performance improvement functions;

   e. not be presently serving as a Medical Staff officer or Board member at another hospital and shall not so serve during the term of office;

f. attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office; and

g. have demonstrated an ability to work well with others.

In exceptional circumstances, the Medical Executive Committee may grant a waiver of one or more of the above eligibility criteria. In making a determination to grant a waiver, the Medical Executive Committee may consider the specific qualifications of the individual in question, input from Medical Staff leadership, the willingness of other practitioners to serve in the leadership position, and the best interests of the Hospital and Medical Staff. No individual is entitled to a waiver or to a hearing if the Medical Executive Committee determines not to grant a waiver. No physician shall simultaneously hold two officer positions.

3. Election of Officers:

a. The President of the Medical Staff shall appoint a Nominating Committee to present a slate of officers for election at least 30 days prior to the General Medical Staff meeting. There shall be at least three members on a Nominating Committee, each from a different Department. The members of the Nominating Committee shall be members of the Active Staff. This Committee shall offer in writing at least one or more nominees for each office.

b. Nominations may also be made from the floor at the annual meeting.

c. Election shall be by show of hands unless a secret ballot is requested by any voting member.

d. If there are three candidates and no candidate receives a majority, there shall be successive balloting with the name of the candidate receiving the fewest votes being omitted from each successive slate until a majority vote is obtained by one candidate.

4. Term of Office:

An officer (except the Immediate Past President) shall be elected for two years. Any officer who has served the maximum term of two (2) years in that office shall not be eligible again for election to that same office for a period of three (3) years. In special circumstances, the maximum term limit for an officer may be waived by the Nominating Committee with the approval of the Medical Executive Committee.

5. Vacancies:

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

6. Removal of Officers:

a. Removal of an elected officer or a member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Active Staff, or by a two-thirds vote of the Medical Executive Committee, or by the Board. Grounds for removal shall be:

1) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

2) failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to the credentialing requirements under these Bylaws, or having automatically relinquished privileges pursuant to these Bylaws;

3) failure to perform the duties of the position held;

4) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

5) an infirmity that renders the individual incapable of fulfilling the duties of that office.

b. At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Active Staff, the Medical Executive Committee, or the Board prior to a vote on removal.

7. Duties of Officers:

a. The President shall:

1) act in coordination and cooperation with the Chief Executive Officer, CPE and Governing Board in all matters of mutual concern within the Hospital;

2) call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;

3) be the Chairperson of the Medical Executive Committee; Serve as an ex-officio member of all other Medical Staff Committees, without vote;

4) appoint Committee members to all standing, special, and multi-disciplinary Medical Staff Committees, except the Medical Executive Committee; and appoint Physician Director(s);

5) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and medical staff policies for implementation of sanctions where these are indicated, and for the Medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

6) represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board and to the CEO;

7) receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care; and

8) serve as representative of the Medical Staff to the Hospital Board of Directors and attend quarterly Board (and selected Board Committee) Meetings.

b. The Vice President shall:

1) in the absence of the President, the Vice President shall assume all duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason. The Vice President shall automatically succeed the President if the latter fails to serve for any reason;

2) the Vice President shall be a member of the Medical Executive Committee;

3) the Vice President shall automatically succeed the President, should the office of President become vacated for any reason during the President's term of office; and

4) the Vice President shall perform such duties as are assigned by the President, the Medical Executive Committee or the Board.

c. The Secretary/Treasurer shall:

1) the Secretary/Treasurer shall cause to be kept accurate and complete minutes of all Medical Staff meetings are kept, attend to all correspondence, and be responsible for any funds of the Medical Staff. The Secretary/Treasurer shall perform such other duties as ordinarily pertain to this office; and

2) the Secretary/Treasurer will be a member of the Medical Executive Committee.

d. The Immediate Past President shall:

1) the Immediate Past President shall serve on the Medical Executive Committee and the Credentials Committee; and

2) the Immediate Past President shall perform such additional or special duties as shall be assigned by the President of the Medical Staff, the Medical Executive Committee or the Board.

C. MEDICAL STAFF MEETINGS

Minutes of all meetings shall be maintained and shall include a record of the attendance and pertinent items of business.

1. General Staff Meetings:

The Medical Staff shall hold a regular staff meeting annually on a date set by the President of the Medical Staff at which officers and any members at-large of the Medical Executive Committee shall be elected. This regular staff meeting shall also be for the purpose of reviewing and evaluating clinical department and committee reports and recommendations, and to act on any other matters placed on the agenda by the President.

2. Special Meetings:

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, at the request of the Board of Directors, the Medical Executive Committee, or not less than

one-fourth of the members of the Active Staff, and shall be held at the time and place designated by the Medical Executive Committee. The special meeting must be called within 15 days of filing a written request. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the President of the Medical Staff by mail. Such a vote shall be valid so long as the question is voted on by a majority of the staff eligible to vote.

3. Quorum:

   Presence of fifty percent (50%) of the total membership of the Active Staff at any regular or special meeting shall constitute a quorum for purposes of amendment of these Bylaws, rules, and regulations, election of officers, and the presence of twenty-five percent (25%) or not less than two shall constitute a quorum for all other actions.

4. Committee and Department Meetings:

   a. Regular Meetings:

      Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least quarterly at a date and time set by the presiding officer to review and evaluate the clinical work of practitioners with privileges in the Department, to consider the findings of ongoing quality assessment, monitoring and evaluation activities, and to discuss any other matters concerning patient care and the activities of the Department.

   b. Special Meetings:

      A special meeting of any Committee or Department may be called by or at the request of the Chairperson thereof, the President of the Medical Staff, one-third of the groups' then members, but no less than two, or the Board of Directors.

   c. Quorum:

      Twenty-five percent (25%), but not less than two, of the active Medical Staff members of a Committee or Department shall constitute a quorum for any meeting.

   d. Manner of Action:

      The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a Committee or Department. Action may be taken without a meeting by a unanimous consent in writing, setting forth the action so taken, signed by each member entitled to vote thereat.

   e. Rights of the Ex Officio Members:

      Persons serving under these Bylaws as ex-officio members of a Committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and shall not be eligible to vote.

f. Minutes:

Minutes of each regular and special meeting of a Committee or Department shall be prepared and shall include a record of the attendance of appointees and the vote taken on each matter.

The Minutes shall be signed by the presiding officer and copies thereof shall be submitted to attendees for approval at the next scheduled meeting, and unless correction is requested within five days, forwarded to the Medical Executive Committee. Each Committee and Department shall maintain a permanent file of the Minutes of each meeting.

5. Provisions Common to All Meetings:

a. Prerogatives of the Presiding Officer:

1) The Presiding Officer/designee of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, or committee.

2) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

3) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings and elections.

b. Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of Departments and Committees shall, unless held pursuant to a resolution, be posted on an electronic delivery system or delivered, either in person or by regular or electronic mail, to each person entitled to be present at such meetings not less than three or more than ~~(~~30~~)~~ working days in advance of such meetings. The notice shall state the date, time, and place of the meeting. When mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each person at the physician's address as it appears on the records of the Hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. The attendance of any person at any meeting shall constitute a waiver of notice of such meeting.

c. Attendance Requirements**:**

1) Each Active Staff Member shall be required to attend at least fifty percent of all regular Medical Staff meetings and applicable regular Department and Committee meetings in each year but is expected to attend all meetings. Any person who is compelled to be absent from any meeting shall promptly submit to the Medical Staff Office the reason for such absence if the individual desires to receive credit for an excused absence at that meeting. Credit shall then be at the discretion of the appropriate presiding officer. The failure of any person required to do so, to meet the foregoing requirements shall constitute grounds for non-reappointment to the Staff.

2) Any Medical Staff Member 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 him advance written notice of the time and place of the meeting at which his attendance is expected. Whenever a concern regarding clinical practice or professional conduct involving any individual is involved, the notice to the individual shall so state, shall be given by certified mail, return receipt requested, and his attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

3) 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 he was given notice that attendance was mandatory. Unless excused by the Medical Executive Committee upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's clinical 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 his absence will be unavoidable, the presentation may be postponed by the Chairperson of his 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.

d. Rules of Order:

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff, Department, or committee custom shall prevail at all meetings, and the Department Chairperson or committee chair shall have the authority to rule definitively on all matters of procedure.

e. Voting:

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

ARTICLE VI: CLINICAL DEPARTMENTS

A. DEPARTMENTS

There shall be six departments of the Medical Staff:

1. Internal and Family Medicine
2. Surgery
3. Pathology
4. Radiology
5. Obstetrics/Pediatrics
6. Emergency Services

Each department shall be headed by a department chairperson. Care of the chemically dependent patient shall fall under the Department of Internal and Family Medicine. The care of psychiatric patients will fall

under the Department of Internal and Family Medicine. The care of the patients in the surgical suite, recovery room, anesthesia service, podiatry service, gynecology service, ambulatory care, dental and wound services shall be assigned to the Department of Surgery. The care of Pediatric patients will fall under the Department of Obstetrics/Pediatrics.

Each department will meet at least quarterly.

B. QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRPERSON

1. Each Chairperson shall:

    a. be an Active Staff member;

    b. be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

    c. satisfy the eligibility criteria in Article VIII, A.

2. Each Chairperson shall be elected by the respective Department for a two year term, subject to the approval of the Board of Directors. Chairpersons may serve successive terms, if elected. Departments may, at their option, elect Vice Chairpersons. Removal of the Chairperson during his term of office may be initiated by two-third majority vote of all the active members of this service, but no such removal shall be effective until it has been ratified by the Medical Executive Committee and by the Board of Directors.

C. MEDICAL STAFF FUNCTIONS

1. A description of other Medical staff committees that perform peer review, systematic monitoring and performance improvement activities, and other review functions delegated to the Medical Staff by the Board are set forth in Article X of this document. The initial credentialing functions shall be performed by the Medical Staff through its Credentials Committee.

2. The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

    a. patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

    b. the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

    c. medical assessment and treatment of patients;

    d. medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

    e. the utilization of blood and blood components, including review of significant transfusion reactions;

f. operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

g. education of patients and families;

h. coordination of care, treatment and services with other practitioners and Hospital personnel;

i. accurate, timely and legible completion of medical records;

j. the required content and quality of history and physician examinations, as well as the time frames required for completion;

k. the use of developed criteria for autopsies;

l. sentinel events, including root cause analyses and responses to unanticipated adverse events;

m. nosocomial infections and the potential for infection;

n. unnecessary procedures or treatment;

o. appropriate resource utilization;

p. appropriateness of clinical practice patterns;

q. significant departures from established patterns of clinical practice;

r. the use of information about adverse privileging determinations regarding any practitioner;

s. review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

t. communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

D. FUNCTIONS OF DEPARTMENT CHAIRPERSON

1. Each Chairperson shall:

a. be accountable to and responsible for professional and Medical Staff administrative activities within the Department;

b. be a member of the Medical Executive Committee; the Department Chairperson shall be accountable to the Medical Executive Committee, giving guidance on the overall Medical Policies of the Hospital and making specific recommendations and suggestions regarding his own Department in order to assure quality patient care;

c. maintain continuing surveillance of the clinical and professional performance of all individuals who have delineated clinical privileges in the Department, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

d. in accordance with guidelines set by the Department, recommend criteria for clinical privileges in the Department;

e. be responsible for enforcement within the Department of the Hospital Policies and Bylaws and the Medical Staff Bylaws, Policies, Rules and Regulations;

f. be responsible for implementation within the Department of actions taken by the Board and the Medical Executive Committee;

g. make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the Department;

h. be responsible for the establishment, implementation and effectiveness of any teaching, education and research programs in the Department;

i. report and recommend to Hospital management when necessary with respect to matters affecting patient care in the Department, including personnel, supplies, special regulations, standing orders and techniques;

j. be responsible for assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

k. be accountable for the integration of the Department into the primary functions of the Hospital;

l. be accountable for the coordination and integration of interdepartmental and intradepartmental services;

m. be responsible for the development and implementation of policies and procedures that guide and support the provision of services;

n. be responsible for recommendations for a sufficient number of qualified and competent persons to provide care or service;

o. be responsible for determination of the qualifications and competence of Department personnel who provide patient care services;

p. be accountable for continuous assessment and improvement of the quality of care and services provided;

q. be accountable for maintenance of quality monitoring programs, as appropriate;

r. be responsible for the orientation and continuing education of all persons in the Department;

s. be responsible for recommendations for space and other resources needed by the Department; and

t. 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.

E. ASSIGNMENT TO DEPARTMENTS

1. The Medical Executive Committee shall, after consideration of the recommendations of the clinical departments, recommend initial Department assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

2. Each staff member must be a member of the Medical Staff in good standing in one Department. A staff member may belong to other Departments with approval of the President of the Medical Staff; however, to maintain voting privileges, must maintain 50% attendance.

F. CREATION OR DISSOLUTION OF DEPARTMENTS

Clinical departments shall be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

1. The following factors shall be considered in determining whether a clinical department should be created:

    a. there exists a number of Medical Staff members who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in these Bylaws);

    b. the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish functions on a routine basis;

    c. a majority of the voting members of the proposed department vote in favor of the creation of a new department;

    d. it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department; and

    e. the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

2. The following factors shall be considered in determining whether the dissolution of a department is warranted:

    a. there is no longer an adequate number of Medical Staff members in the department to enable it to accomplish the functions set forth in these Bylaws;

    b. there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;
    c. the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

    d. no qualified individual is willing to serve as chairperson of the department; or

    e. a majority of the voting members of the department vote for its dissolution.

G. FUNCTIONS OF PHYSICIAN DIRECTORS

Physician Directors may be appointed to serve clinical service areas as deemed appropriate and will be responsible for medically related policies and procedures within the Service area.

ARTICLE VII: COMMITTEES

There shall be standing and special Committees within the medical organization for the purpose of fulfilling the Staff functions. These Committees and any other special Committees which may be appointed from time to time to deal with specific issues shall be responsible to the Medical Executive Committee. Assignments and reassignments to Committees shall be made by the President of the Medical Staff on an annual basis, except for assignments to the Credentials Committee and Practitioner Health Committee which shall be for three year terms (appointments to the Credentials Committee shall be made so that if possible, one-third of the Credentials Committee is reappointed each year).

Unless otherwise provided in these Bylaws, committee chairs and members shall be appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee. Committee chairs and members shall be appointed for initial terms of one year, but may be reappointed for additional terms. The President of the Medical Staff and the Chief Executive Officer (or their respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise stated.

A. MEDICAL EXECUTIVE COMMITTEE

1. Composition:

   The Medical Executive Committee shall be a standing committee and shall consist of the Officers of the Medical Staff, the Immediate Past President of the Medical Staff, the chairperson of each clinical department, two at-large physician members of the Active Medical Staff, the CEO and the CPE. The at-large physician members are to be elected by the General Medical Staff at the time of the annual election of officers and to serve a one-year term. The President of the Medical Staff shall be the Chairperson of the Medical Executive Committee. All members of the Medical Executive Committee shall have a vote, except the CEO and the CPE, who shall both be ex-officio members without vote.

2. Duties:

   The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The duties of the Medical Executive Committee shall be:

   a. to act on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

   b. to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

   c. to coordinate the activities and general policies of the various Departments;

d. to receive and act upon Departmental and Committee reports and make recommendations concerning them to the CEO and the Board;

e. to implement policies of the Medical Staff not otherwise the responsibility of the Departments;

f. to provide liaison between the Medical Staff and the Chief Executive Officer and the Board of Directors;

g. to recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

h. to make recommendations on Hospital management matters (for example, long-range planning) to the Board of Directors through the Chief Executive Officer;

i. 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;

j. to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

k. to review situations involving questions of clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee and take appropriate action when warranted;

l. to be responsible to the Board for the implementation of the Hospital's quality assessment/performance improvement plan as it affects the Medical Staff;

m. to review the bylaws, policies, rules and regulations, and associated documents of the Medical Staff, as may be necessary or desirable, but at least every three (3) years, and recommend such changes to the Board;

n. to determine minimum continuing education requirements for appointees to the staff;

o. to review the credentials of all applicants and make recommendations to the Board for appointment to the Medical Staff, assignment to a clinical department and delineation of clinical privileges;

p. to review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and as a result of such review make recommendations to the Board for reappointments, clinical privileges and/or changes in clinical privileges;

q. to organize the Medical Staff's performance improvement activities and establish a mechanism to conduct, evaluate, and revise such activities;

r. to advise Hospital administration on quality-related aspects of contracts for patient care services;

s. to review and approve all standing orders and protocols for consistency with nationally recognized and evidence-based guidelines;

t. to provide leadership in activities related to patient safety;

u. to provide oversight in the process of analyzing and improving patient satisfaction;

v. to make recommendations to the Board with regard to the Medical Staff's structure;

w. to recommend directly to the Board with regard to the mechanism used to review credentials and delineate individual clinical privileges, the mechanism by which Medical Staff appointment may be terminated, and hearing procedures; and

x. to perform such other functions as are assigned by these bylaws, regarding medical staff appointment, reappointment and clinical privileges or other applicable policies.

3. Meetings, Reports and Recommendations:

The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and action. Special meetings may be called by the Chairperson or at the request of the Board of Directors, the Chief Executive Officer, or three (3) members of the Committee. If a Department Chairperson is aware he will be unable to attend a scheduled Medical Executive Committee meeting, he may appoint a representative such as the Immediate Past Chairperson or the Vice Chairperson to attend the meeting, with vote, in his place. Attendance at Medical Executive Committee meetings is limited to members of the Committee and invitees of the Committee Chairperson.

Between meetings of the Medical Executive Committee, an ad hoc committee composed of the officers of the staff and the Chairperson of the Credentials Committee shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws.

B. BYLAWS COMMITTEE

1. Composition:

The Bylaws Committee shall be a standing Committee composed of members of the Active Medical Staff and appropriate representation from administration.

2. Duties:

The Bylaws Committee shall:

a. review the bylaws of the Medical Staff, the Medical Staff rules and regulations, and other Medical Staff associated documents, as may be necessary or desirable, but at least every three (3) years, and recommend amendments as appropriate to the Medical Executive Committee; and

b. receive and consider all recommendations for changes in these documents made by the Board, any Medical Staff committee department, any individual appointed to the Medical Staff, and the CEO.

3. Meetings:

The Medical Staff Bylaws Committee shall meet as often as necessary to fulfill its duties, but, and shall make a written report of its findings, proceedings, actions, and recommendations after each meeting to the Medical Executive Committee and the Hospital CEO.

C. CREDENTIALS COMMITTEE

1. Composition:

a. The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of five physician members of the Active Staff, including the Immediate Past President of the Medical Staff who shall service as Committee Chairperson, one (1) member each of the Departments of Internal and Family Medicine, Surgery, and Obstetrics/Pediatrics, and one hospital-based member of the Department of Pathology, Radiology, or Emergency Services.

Service on this committee shall be considered a primary Medical Staff obligation of each member and other Medical Staff duties shall not interfere. Individuals serving on the Credentials Committee, with the exception of the Immediate Past President of the Medical Staff, shall not serve on the Medical Executive Committee at the same time. There shall be appropriate representation from administration.

b. If at any time the continued workability of the committee is threatened by the inability or unwillingness of any of the individuals to serve, the President of the Medical Staff shall appoint up to five additional members from the respective departments to the committee, for terms of one year each, to fill the vacancies.

c. Members of the Credentials Committee shall serve for three years with successive terms.

2. Duties:

The Committee shall carry out the following functions:

a. review and evaluate the qualification and credentials of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges, and in connection therewith to obtain and consider the reports of the appropriate Departments to make recommendations and reports for Staff membership, assignments to Departments, and delineation of clinical privileges;

b. review and evaluate the qualifications of each applicant for staff membership or particular clinical privileges and of each Allied Health practitioner for specified services. Such reports shall include evaluations with respect to appointment, staff category, Department affiliation, clinical privileges, or specific services and special conditions attached thereto;

c. review and evaluate the qualifications of each Allied Health Affiliate applying to perform specified services, and in connection therewith to obtain and consider the evaluations and/or reports of the appropriate Departments;

d. investigate, review and report on matters, including the clinical or ethical conduct of any practitioner, (to include chronic problems with interactions, incompletion of medical records, etc.) assigned or referred by: a) the President of the Staff, or b) Medical Executive Committee, or c) any other Committee or Department; and

e. submit reports on a regular basis to the Medical Executive Committee on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

3. Meetings:

The Credentials Committee shall meet as often as necessary to accomplish its duties, but at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Medical Executive Committee, the CEO and the Board. The Chairperson of the Credentials Committee shall be available to meet with the Board or the Executive Committee of the Board on all recommendations that the Credentials Committee may make.

D. SPECIAL COMMITTEES

Members of the Medical Staff shall also serve on Hospital and Board Committees as appointed by the President of the Medical Staff or as appointed by the Board of Directors or the Chief Executive Officer.

The Hospital may establish an Infection Control Committee that shall act as a Committee of the Hospital and be represented by members of this Medical Staff.

E. CREATION OF STANDING COMMITTEES

1. The Medical Executive Committee of the Medical Staff may, by resolution and upon approval of the Board, without amendment of the bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions.

2. The Medical Executive Committee, without the approval of the Medical Staff, may establish ad hoc committees with specific duties for the purpose of assisting the Medical Staff in its determination to establish a standing committee to perform the duties performed by the ad hoc committee.

3. Any function required to be performed by the bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

ARTICLE VIII: APPOINTMENT TO THE MEDICAL STAFF

A. QUALIFICATIONS FOR APPOINTMENT

1. General:

Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent physicians who continuously meet the qualifications, standards and requirements sets forth in these Bylaws and in such policies as are adopted from time to time by the Board. All

individuals practicing in this Hospital, except under specific provisions of these Bylaws, must first have been appointed to the Medical Staff.

2. Specific Qualifications:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

a. have a current, unrestricted license to practice in the State of Wisconsin and have never had a license to practice revoked or suspended by any state licensing agency;

b. where applicable to their practice, have a current, unrestricted DEA registration;

c. be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

d. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

e. have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;

f. have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

g. have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

h. have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

i. have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

j. agree to fulfill all responsibilities regarding emergency call for their specialty;

k. have or agree to make coverage arrangements with other Members of the Medical Staff for those times when the individual will be unavailable;

l. have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those individuals who apply for initial staff appointment on or after May 12, 2011; and

m. be board certified in their primary area of practice at the Hospital. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. (This requirement is applicable only to those individuals who apply for initial staff appointment after May 12, 2011. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments).

3. Waiver of Threshold Eligibility Criteria:

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

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

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

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

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

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

4. Factors for Evaluation:

   Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

   a. relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

b. adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

c. good reputation and character;

d. ability to safely and competently perform the clinical privileges requested;

e. ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other Members of health care teams; and

f. recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

5. Ethical and Religious Directives:

All Medical Staff members and others exercising clinical privileges or a scope of practice in the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by the Directives shall be engaged in by any Medical Staff member or other person exercising clinical privileges or a scope of practice at the Hospital.

6. 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 his profession in this or any other State, (b) is a Member of any particular professional organization, or (c) has had in the past, or currently has, Medical Staff appointment or privileges in this or another Hospital, or (d) is certified by any medical specialty board, or (e) resides in the geographic service area of the Hospital; or (f) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

7. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

B. CONDITIONS OF APPOINTMENT

1. Rights and Duties of Members:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and Member specifically agrees to the following:

a. to provide continuous care and supervision of the generally, professionally recognized level of quality and efficiency to all patients within the Hospital for whom the individual has responsibility;

b. to abide by the Bylaws and Policies of the Hospital, including all Bylaws, Policies and 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. to attend medical staff orientation including training on the use of the electronic medical record prior to being allowed to exercise clinical privileges;

d. to accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and by performing such other reasonable duties and responsibilities as may be assigned;

e. to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or to clearly document the clinical reasons for variance;

f. to maintain a current e-mail address (if available) with the Medical Staff Office, through which the Medical Staff leadership and Hospital may provide notice. E-mail notice will not be used exclusively for time-sensitive or urgent information exchange;

g. to inform the Chief Executive Officer and the President of the Medical Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other Hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

h. to immediately submit to a blood, hair and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one Member of the Administrative team) are concerned about the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;

i. to appear, if requested, for personal interviews in regard to an application for initial appointment or reappointment;

j. to comply with all medical staff policies and requirements regarding the use of electronic medical records;

k. to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

l. to refrain from delegating responsibility for Hospitalized patients to any individual who is not qualified or adequately supervised;

m. to refrain from deceiving patients as to the identity of any individual providing treatment or services;

n. to seek consultation whenever necessary;

o. to abide by generally recognized ethical principles applicable to the individual's profession;

p. to participate in monitoring and evaluation activities;

q. to complete in a timely manner all medical (including electronic) and other required records, containing all information required by the Hospital;

r. to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

s. to promptly pay any applicable dues, assessments, and/or fines;

t. to undergo a tuberculin test as a condition of initial appointment, and at reappointment as requested;

u. to provide documented evidence of influenza vaccination status or reason for declination annually, as requested;

v. to abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church and to refrain from performing any activity prohibited by said Directives;

w. to participate in an Organized Health Care Arrangement with the Hospital and to abide by the terms of the Hospital's Notice of Privacy Practices with respect to care delivered in the Hospital;

x. to satisfy continuing medical education requirements; and

y. that any misstatement in, or omission from, the application is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

2. Professional Conduct:

Individuals appointed to the Medical Staff shall be expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical staff leadership and Hospital management and personnel. Professional conduct shall also include, but not be limited to, each appointee's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

C. APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

1. Request for Application:

   a. An individual requesting an application for appointment to the Medical Staff shall be told by the Medical Staff Office that an application will only be forwarded to those individuals who can document that they meet all of the eligibility criteria set forth in Part A, Section 1 of this Article, who desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel, and who indicate an intention to use the Hospital as required by the staff category to which they desire appointment.

   b. An individual requesting an application for appointment shall initially be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges consideration. Those individuals who meet the eligibility criteria for consideration for appointment to the Medical Staff and clinical privileges shall be given an application. Individuals who fail to meet the threshold criteria shall not be given an application and shall be notified that they are ineligible to apply. There is no right to a hearing on a determination of ineligibility.

   c. A completed application form with copies of all required documents must be returned to the Medical Staff Office within 90 days of being sent to the applicant. Incomplete applications shall not be processed. Individuals who fail to return a completed application or fail to meet the threshold criteria shall be notified that their applications shall not be processed.

   d. The issuance of an application does not indicate or guarantee that the application or any privileges shall be recommended or granted.

   e. Expedited credentialing may be granted by the Executive Committee of the Board of Directors upon the recommendation of the appropriate department chairperson and either the Credentials Committee Chair or Medical Staff President in accordance with the Expedited Credentialing Policy.

2. Information:

   a. Applications for appointment to the Medical Staff shall be submitted on a form approved by the Board upon recommendation of the Credentials and Medical Executive Committees and obtained from the Medical Staff Office. The application shall include the payment of such processing fees as may be recommended by the Medical Executive Committee and approved by the Board.

   b. The application shall contain a request for specific clinical privileges and shall require detailed information concerning the applicant's professional qualifications including:

      1) the names and complete addresses of at least two (2) physicians, dentists, podiatrists or other practitioners, as appropriate, who have had extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. References may not be from individuals personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;

2) the names and complete addresses of the individuals who served as chairpersons at the time the applicant worked in the particular department of any and all hospitals or other institutions. 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 Committee (and Medical Executive Committee) and the Board may take into consideration such factors;

3) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

4) information as to whether the applicant has ever voluntarily or involuntarily withdrawn an application for appointment, reappointment and clinical privileges, not including a voluntary personal decision by the applicant to request a lesser scope of clinical privileges upon reappointment or during the term of appointment, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;

5) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted or is currently being challenged;

6) documentation concerning the applicant's current professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance coverage covers the clinical privileges requested, and whether any restrictions have been imposed on the applicant's liability coverage;

7) a consent to the release of information from the applicant's present and past professional liability insurance carriers;

8) information concerning pending professional liability litigation, final judgments or settlements:

   a) the substance of the allegations;

   b) the findings;

   c) the ultimate disposition; and

   d) any additional information the Credentials or Medical Executive Committees or the Board may deem appropriate;

9) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, and whether such proceedings are closed or still pending;

10) information concerning the suspension or termination for any period of time in Medicare, Medicaid, any other government sponsored program, or any private or public medical

insurance program, and information as to whether the applicant is currently under investigation;

11) current information regarding the applicant's ability to exercise the privileges requested competently and safely and to perform the duties and responsibilities of appointment;

12) information as to whether the applicant has ever been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, Medicare, Medicaid or insurance or health care fraud or abuse, or violence;

13) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

14) information on the citizenship or visa status of the applicant;

15) the applicant's signature; and

16) such other information as the Board may require.

c. The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular clinical privilege requested, or general behavior.

3. Applicant's Signature:

The applicant's signature shall constitute agreement:

a. 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, and agrees to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and clinical privileges are granted;

b. that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall result in no further processing. If appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic relinquishment of all clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal;

c. that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;

d. authorize the release of all information necessary for an evaluation of the individual's qualifications; and

e. extend, to the fullest permitted by law, immunity to the Hospital, its Medical Staff and all individuals acting for the Hospital and/or its Medical Staff in matters relating to appointment, reappointment and clinical privileges.

4. Burden of Providing Information:

a. The applicant shall have the burden of producing adequate information for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

b. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

c. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

d. Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

e. Applicants are responsible for notifying the Credentials Committee (via the Medical Staff Office) of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but is not limited to:

1) any information on the application form;

2) any threshold eligibility criteria for appointment or clinical privileges;

3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

4) changes in professional liability insurance coverage;

5) the filing of a professional liability lawsuit against the practitioner;

6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and

8) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health issues, including, but not limited to, impairment due to addiction.

5. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

a. Immunity:

To the fullest extent permitted by law (including but not limited to Wisconsin Statutes Section 146.38 and the Federal Health Care Quality Improvement Act), the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, the CVO, any Member of the Medical Staff or the Board, their authorized representatives, or any third parties providing information to or receiving information from the Hospital with respect to any acts, communications, documents, or disclosures relating to the individual's application for appointment, reappointment, clinical privileges, including temporary privileges or any other professional review activity or matter that might directly or indirectly relate to the individual's competence, to patient care, or to the orderly operation of this or any other hospital or healthcare facility. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

b. Use and Disclosure of Information:

1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, clinical privileges, or scope of practice, or the individual's qualifications for the same, including, but not limited to:

a) information pertaining to the individual's clinical competence, professional conduct, character, reputation, ethics, and ability to practice safely with or without accommodation, and any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff;

b) any matters addressed on the application form or in the Medical Staff Bylaws, Hospital or Medical Staff policies and Rules and Regulations;

c) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

d) any references received or given about the individual.

2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

3) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates to share information with one another.

4) Authorization to Obtain Information from Third Parties:

The individual authorizes the CVO, Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

c. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

d. Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any Member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

e. Scope of Section:

All of the provisions in this Article are applicable in the following situations:

1) whether or not appointment or clinical privileges are granted;

2) throughout the term of any appointment or reappointment period and thereafter;

3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Medical Center's professional review activities; and

4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Medical Center.

6. Contract Physicians:

In the case of Physicians or other individuals actively serving in Administratively responsible capacities in the Hospital pursuant to a contract, the continuation of clinical privileges will not be contingent on continuance of the contractual arrangement.

D. PROCEDURE FOR INITIAL APPOINTMENT

1. Submission of Application:

    a. After reviewing the application to determine that all questions have been answered, after reviewing all references and other information or materials deemed pertinent, after querying the National Practitioner Data Bank, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chairperson for further evaluation.

    b. An application shall become incomplete if the need arises at any time for new, additional or clarifying information. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. The applicant shall be responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2. Department Chairperson Procedure:

    a. The Chairperson of each Department in which the applicant seeks clinical privileges shall provide the Credentials Committee with a specific written report as to the applicant meeting applicable criteria for clinical privileges requested in the specialty areas represented by the Department. As part of the process of making this report, the Department Chairperson may meet with the applicant to discuss any aspect of his application, his qualifications and requested clinical privileges.

    b. The Department Chairperson or other individual within the Department shall evaluate the applicant's education, training, experience and conduct and make inquiries with respect to the applicant's past or current department chairperson(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The clinical department chairperson shall be available to the Credentials Committee to answer any questions that may be raised with respect to their report and findings.

3. Credentials Committee Procedure:

    a. The 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 the report and findings from the department chairperson of each department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

    b. As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the applicant's application, qualifications, and/or clinical privileges requested.

c. The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

d. The name of the applicant shall be posted or circulated so that each Medical Staff appointee may have an opportunity to submit to the Credentials Committee, in writing, information bearing on the applicant's qualifications for staff appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

e. After determining that the applicant is qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee. The results of any examination shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application and all processing of the application shall cease.

f. If, after considering the report of the department chairperson concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend appointment and department assignment. All recommendations to appoint must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the committee.

g. If the recommendation of the Credentials Committee is delayed longer than ninety (90) days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and CEO, explaining the reasons for the delay.

4. Credentials Committee Report:

a. Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation, written findings and all supporting documentation to the Medical Executive Committee.

b. The Chairperson of the Credentials Committee shall be available to the Medical Executive Committee (and to the Board or Executive Committee of the Board) to answer any questions that may be raised with respect to the Credentials Committee's findings and recommendation.

5. Medical Executive Committee Recommendation:

a. At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

1) adopt the findings and recommendation of the Credentials Committee as its own; or

2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, to the Board (or the Executive Committee of the Board).

b. If the recommendation of the Medical Executive Committee is to appoint, the recommendation shall be forwarded to the Board (or Executive Committee of the Board) through the CEO.

c. If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal. The CEO shall, thereafter, forward the recommendation of the Medical Executive Committee, together with the complete application and all supporting documentation to the Board (or the Executive Committee of the Board) for further action.

6. Board Action:

Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board (or the Executive Committee of the Board) may:

a. appoint the applicant and grant clinical privileges as recommended; or

b. refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

c. reject or modify the recommendation. If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly notify the applicant by special notice that he or she is entitled to request a hearing.

7. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

E. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

1. Application:

a. Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form. An application for

reappointment shall be furnished to members at least ninety (90) days prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office or designated CVO within thirty (30) days.

b. Failure to submit an application for reappointment at least two months prior to the expiration of the member's current term will result in automatic expiration of the individual's appointment and clinical privileges at the end of the current term of appointment, unless the application can still be processed in the normal course. The individual may not practice until the application is completely processed.

c. Reappointment, if granted by the Board, shall be for a period of not more than two (2) years, with reappointments staggered in a manner established by the Medical Staff Office.

d. If an application for reappointment is filed timely and the Board has not acted on it prior to the expiration of the individual's current appointment term, the CEO shall have the authority to grant the individual temporary appointment and clinical privileges, if applicable, until such time as the Board (or the Executive Committee of the Board) can act on the application, if an important patient care need exists. Temporary privileges shall be granted only in accordance with these Bylaws.

e. In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

f. The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment consideration and for the clinical privileges requested.

g. The Medical Staff Office shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

h. The Medical Staff Office shall forward the application to the department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

2. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

a. completed all medical records;

b. completed all continuing medical education requirements;

c. satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

d. continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

e. any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary Hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and

f. paid any applicable reappointment processing fees.

3. Factors to be Considered:

In considering an individual's application for reappointment, the factors listed in Article VIII, Section A of these Bylaws will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

a. patient contacts at the Hospital during the previous appointment term;

b. ethical behavior, and current clinical competence, judgment and technical skill in the treatment of patients;

c. participation in staff responsibilities;

d. compliance with the Bylaws, policies and Rules and Regulations of the Medical Staff and the Hospital;

e. behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, and the ability to work with others;

f. use of the Hospital's facilities for patients, taking into consideration the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified), practitioner-specific information compared to aggregate data, including, but not limited to, conformity to clinical protocols or pathways;

g. current ability to perform the clinical privileges requested competently and safely;

h. capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment/performance improvement activities or other reasonable indicators of continuing qualifications, including reports from the National Practitioner Data Bank and any current malpractice actions;

i. satisfactory completion during the previous appointment term of applicable continuing education requirements as may be imposed by law, regulation, applicable accreditation agencies, and the Hospital;

j. current professional liability insurance status and pending malpractice claims, lawsuits, judgments and settlements;

k. current licensures, including pending challenges to any license or registration;

l. voluntary or involuntary termination of Medical Staff appointment, limitation, reduction, or loss of clinical privileges at another hospital;

m. any focused professional practice evaluations;

n. verified complaints received from patients and/or staff; and

o. other reasonable indicators of continuing qualifications.

To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the clinical department chairperson and the Credentials Committee to assess the applicant's current clinical competence for the privileges requested. Any individual seeking reappointment who has minimal activity at this Hospital must submit a copy of his or her confidential QA profile from the individual's primary hospital, if applicable, and/or such other information as may be requested, before the individual's reappointment application shall be considered complete and processed further.

4. Processing Applications for Reappointment:

a. The Chief Executive Officer shall forward the application to the relevant Department Chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

b. If it becomes apparent to the Credentials Committee that it is considering a recommendation to deny reappointment, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5. Conditional Reappointments:

a. Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Article XII of these Bylaws, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article XII of these Bylaws.

b. In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

c. In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be

imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article XII.

6. Time Periods for Processing:

   Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

F. PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

1. Application for Increased Clinical Privileges:

   Whenever, during the term of his appointment or at the time of reappointment to the Medical Staff, an individual desires to increase his clinical privileges, he shall apply in writing to the Chief Executive Officer on a privilege form approved by the Board. The request shall state in detail the specific additional clinical privileges desired and sufficient information to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application complete, it shall be transmitted by the Medical Staff Office 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 a part of the reappointment application if the request is made at that time.

2. Factors to be Considered:

   a. Recommendations for additional 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 assessment/performance improvement activities; and

      5) other reasonable indicators of the individual's qualifications for the privileges in question.

   b. The recommendation for additional privileges may include requirements for supervision or other conditions for such periods of time as are thought necessary.

G. LEAVE OF ABSENCE

1. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President of the Medical Staff. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

2. Members of the Medical Staff must report to the Medical Executive Committee any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for

patients safely and competently. Under such circumstances, the Medical Executive Committee, in consultation with the Chief Executive Officer, may trigger an automatic leave of absence.

3. The Medical Executive Committee shall determine whether a request for a leave of absence shall be granted, subject to the approval of the Board. In determining whether to grant a request, the Medical Executive Committee shall consult with the Chief Executive Officer and the relevant department chairman. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

4. A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations. Medical staff members who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring as determined by the Department Chair or Credentials Committee, based on an evaluation of the nature of activities during the leave.

5. During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6. Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant department chairman and the Chair of the Credentials Committee. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

7. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. At the request of the Medical Executive Committee or Board, the individual may be required to submit to a medical examination by a practitioner acceptable to the Medical Staff leadership and Hospital.

8. Absence for longer than one year (except for military service) shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer. As a general rule, extensions will be granted to allow a member to complete mandatory military service. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

9. If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply for reappointment.

10. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE IX: CLINICAL PRIVILEGES

A. GRANTS OF CLINICAL PRIVILEGES

1. General:

   a. Appointment or reappointment will not automatically confer any clinical privileges or right to practice at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

   b. In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

   c. Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

   d. Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria.

   e. The clinical privileges recommended to the Board will be based on consideration of the following:

      1) education, relevant training, experience, and demonstrated current competence of the health care team and peer evaluations relating to these criteria; , including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other Members;

      2) appropriateness of utilization patterns;

      3) ability to perform the privileges requested competently and safely;

      4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

      5) availability of qualified staff Members to provide coverage in case of the applicant's illness or unavailability;

      6) adequate professional liability insurance coverage for the clinical privileges requested;

      7) the Hospital's available resources and personnel;

      8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Hospital;

10) practitioner-specific data as compared to aggregate data, when available;

11) morbidity and mortality data, when available;

12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions; and

13) other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which privileges are sought.

f. The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

g. The report of the Chairperson of the Department in which privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

2. Special Conditions for Dental Privileges:

Requests for clinical privileges from dentists shall be processed in the same manner as is outlined in the Bylaws for other Medical Staff privileges. Surgical procedures performed by Dentists shall be under the supervision of the Chairperson of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician Member of the Medical Staff shall be responsible for preparation of the medical history and physical of a dental patient and for any other medical problem at the time of admission or during Hospitalization. Dentists may serve on Medical Staff committees. Oral Surgeons may perform and complete a medical history and physical examination if they can provide evidence of traditional medical training and experience to perform such which is satisfactory to the Credentials Committee of the Medical Staff. Oral Surgeons shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in Oral and Maxillofacial Surgery, accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association.

3. Special Conditions for Podiatric Privileges:

Requests for clinical privileges from podiatrists shall be processed in the same manner as is outlined in these Bylaws for other Medical Staff privileges. Surgical procedures performed by Podiatrists shall be under the supervision of the Chairperson of the Department of Surgery. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. Podiatrists who admit patients without underlying health problems, defined as ASA class I or II, 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 Credentials Committee. Podiatrists may serve on Medical Staff Committees.

4. Residents:

a. Residents in training at the Hospital shall **not** hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Medical Executive Committee or its designee and the Board or its designee. The program director, clinical faculty and/or a designated Medical Staff appointee shall be responsible for the direction and supervision of the on-site, day-to-day patient care activities of each resident.

b. The clinical functions granted to residents shall be limited to the specialty and duration of the resident's training program and shall be subject to supervision at all times as specified by residency manuals and policies and the ACGME, AOA, American College of Osteopathic Family Physicians, and Council on Podiatric Medical Education guidelines.

c. The program director shall be responsible for verifying and evaluating the qualifications of each resident.

d. Medical Staff appointees who participate in overseeing residents shall be provided with a written description of the role, responsibilities and patient care activities of the residents. These descriptions shall include identification of the mechanisms by which the supervising physician and program director make decisions regarding each resident's progressive involvement and independence in specific patient care activities.

e. The residency program director shall report to the Medical Executive Committee at least yearly concerning:

   1) the educational programs being offered at the Hospital;

   2) written descriptions of the role, responsibilities and patient care activities of the residents;

   3) the safety and quality of patient care provided by the program participants;

   4) the related educational and supervisory needs of the residents; and

   5) the delineation of who may write patient care orders, the circumstances under which they may do so and what entries, if any, must be countersigned.

5. <u>Clinical Privileges for New Procedures</u>:

   a. Requests for clinical privileges to perform a procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), will not be processed until:

      1) a determination has been made that the technique/procedure/service will be offered by the Hospital; and

      2) criteria for the clinical privilege(s) have been adopted.

   b. As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson and the Credentials Committee addressing the following:

1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

2) clinical indications for when the new procedure is appropriate;

3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chairperson and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

c. If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

1) the clinical indications for when the procedure or service is appropriate;

2) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

3) the Credentials Committee shall forward its recommendation to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board (or the Executive Committee of the Board) for final action.

6. Clinical Privileges That Cross Specialty Lines:

a. Requests for clinical privileges that previously have been exercised only members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privileges in question.

b. As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual’s specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

c. The Credentials Committee will verify that the privilege(s) is not subject to an exclusive agreement.

d. The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other Hospitals, residency training programs, specialty societies).

e. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

2) the clinical indications for when the procedure is appropriate;

3) the manner of addressing the most common complications that arise, which may be outside the scope of the clinical privileges that have been granted to the requesting individual;

4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing focused professional practice evaluation (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

6) the impact, if any, on emergency call responsibilities.

f. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

7. Supervision of Allied Health Professionals:

Any physician who employs an allied health professional to perform clinical activities/functions in the Hospital shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of that allied health professional. All physicians employing such individuals are advised to consult these Bylaws for details concerning the use of allied health professionals in the Hospital.

8. Telemedicine Privileges:

a. Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. Telemedicine services can be provided simultaneously (i.e. teleICU) or non-simultaneously (i.e. Teleradiology). The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson, the Credentials Committee, and the Medical Executive Committee.

b. Individuals applying for telemedicine privileges will meet the qualifications for Medical Staff appointment outlined in these Bylaws, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.

c. Individuals who hold privileges in other classifications of the Medical Staff are not required to apply for telemedicine privileges in order to use electronic communication or other communication technology to provide or support clinical care at a distance.

d. Qualified applicants may be granted telemedicine privileges but will not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

e. Applications for telemedicine privileges will be processed in accordance with the provisions of these Bylaws in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by a telemedicine entity (as that term is defined by CMS) if the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or the applicant's primary hospital/group, provided that hospital/group is accredited by the Joint Commission. There must be a written contract between the primary hospital/group and the Hospital, the applicant must be privileged at the primary hospital/group for the privileges being requested, the primary hospital/group must provide evidence of an internal review of the practitioner's performance of the privileges, and the primary hospital/group must provide information about adverse events that resulted from the telemedicine services and any complaints they received about the practitioner.

f. Telemedicine privileges, if granted, will be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.

g. Individuals granted telemedicine privileges will be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the Hospital or entity providing telemedicine services.

9. Contracted Services:

a. It is understood that the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals providing services pursuant to those contracts must obtain and maintain Medical Staff appointment and clinical privileges at the Hospital, in accordance with the terms of these Bylaws.

b. As a practical matter, if an exclusive contract confers the exclusive right to perform certain services at the Hospital, other individuals cannot exercise clinical privileges to perform those services while the contract is in effect.

c. Therefore, if an exclusive contract would effectively prevent an existing Medical Staff member from exercising clinical privileges that had previously been granted, the Board will notify the member and invite the member to meet with the Board or its designee to discuss the matter and present any information that the member believes is relevant to the Board's decision to enter into the exclusive contract. Individuals are not entitled to any other procedural rights with respect to the Board's decision to enter into an exclusive contract or the effect of any such contract on the member's clinical privileges. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the Wisconsin licensure board or to the National Practitioner Data Bank.

d. In the event of any conflict between the Medical Staff Bylaws and the terms of any contract, the conflict shall be handled in accordance with the Conflict Management Process further described in these Bylaws.

B. PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

1. Temporary Clinical Privileges for Applicants:

a. Temporary clinical privileges may be granted by the CEO, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment or service need. Specifically, temporary privileges may be granted for the following reasons:

1) the care of a specific patient;

2) when necessary to prevent a lack or lapse of services in a needed specialty area; or

3) when a physician is participating as a student in a special training program offered at the Hospital under the supervision of a member of the Medical Staff.

Prior to granting temporary privileges in these situations, the CEO shall verify current licensure and current competence.

b. Temporary privileges may be granted only after the CEO has consulted with the applicable clinical department chairperson and the Chairperson of the Credentials Committee.

c. Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

d. Temporary privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding ninety (90) days.

e. Temporary privileges shall expire at the end of the time period for which they are granted.

f. In exercising such privileges, the applicant shall act under the supervision of the clinical department chairperson of the department in which the applicant has requested primary privileges.

2. Termination of Temporary Clinical Privileges:

a. The CEO may, at any time after consulting with the President of the Medical Staff, the Credentials Committee Chairperson or the department chairperson responsible for the individual's supervision, terminate temporary admitting privileges. The termination shall then be effective when the individual's patients are discharged from the Hospital, or effective immediately if it is determined that the care or safety of patients would be endangered by continued treatment by the individual granted temporary privileges, or if the individual fails to comply with any condition.

b. The appropriate department chairperson or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

c. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial nor termination of such privileges shall entitle the individual to request a hearing.

d. Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends not to appoint the applicant to the staff. Similarly, temporary clinical privileges shall be modified to conform to the recommendation of the Credentials Committee (and/or the Medical Executive Committee) that the applicant be granted clinical privileges different from the temporary privileges.

C. Locum Tenens

1. The CEO, after consulting with the President of the Medical Staff, the clinical department chairperson, and the Credentials Committee chairperson, may grant temporary admitting and clinical privileges to an individual serving as a locum tenens for an appointee of the Medical Staff to attend patients of that appointee, or may grant locum tenens privileges at the request of the Hospital to provide coverage in a specialty area in which there is no coverage or a shortage of individuals to provide coverage.
2. Prior to granting locum tenens privileges, the CEO or designee shall verify the individual's licensure, DEA and state controlled substance certification, character, ethical standing, ability to perform the privileges requested competently and safely, and professional liability insurance coverage; query the National Practitioner Data Bank; and obtain the individual's signed acknowledgment to be bound by all of the Bylaws, policies, Rules and Regulations of the Medical Staff and the Hospital. Verification of board certification with participation in a Program for Maintenance of Certification (MOC) or completion of 30 hours of continuing medical education within the previous two years is also required prior to granting locum tenens privileges.

3. Locum tenens coverage shall be limited to a time frame not to exceed one hundred twenty (120) days annually, unless such time limitation is waived by the Board or its designee in those

situations where there is no medical coverage and the desired specialty or a physician shortage exists in a clinical specialty area.

4. Locum tenens designation is a courtesy offered by the Hospital for Medical Staff appointees who are unavailable, or when necessary to the Hospital while it implements the Board's Medical Staff strategic planning objectives.

D. EMERGENCY PRIVILEGES

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) and in which any delay in administering treatment would add to that harm.

1. In an emergency, any practitioner who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to the extent permitted by that individual's license regardless of that individual's clinical department status or specific grant of clinical privileges.

2. When the emergency situation no longer exists, the patient shall be assigned by the President of the Medical Staff or his designee to an appropriate physician currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

E. MASS DISASTERS

1. Disaster privileges may be granted when the emergency management plan has been activated and the Hospital is unable to provide all the care required by individuals seeking treatment at the Hospital. Under such circumstances, the CEO or the President of the Medical Staff, or a designee may grant privileges or permission to treat patients to volunteer physicians, nurses and other health care professionals upon satisfactory evidence of 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:

    a. a current picture hospital ID card;

    b. a current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

    c. identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organizations or groups;

    d. identification indicating that the individual has been granted authority to render patient care in disaster circumstances, such as authority having been granted by a federal, state or municipal entity; and/or

    e. presentation by or verification from a current hospital or Medical Staff appointee with personal knowledge regarding a practitioner's identity.

2. The CEO and/or President of the Medical Staff is not required to grant disaster privileges to any individual and is expected to exercise discretion and make such decisions on a case-by-case basis.

3. Individuals granted disaster privileges shall function within the scope of their license and/or as directed by the disaster coordinator.

4. Volunteer practitioners granted disaster privileges shall be provided with a hospital-approved identification badge indicating their provider level and specialty.

5. The verification process of the credentials and privileges of individuals who receive disaster privileges shall begin as soon as the immediate disaster situation is under control and must be completed within 72 hours from the time the volunteer begins to provide services at the Hospital. The process established under the bylaws regarding Medical Staff appointment, reappointment and clinical privileges for the granting of temporary privileges shall be implemented.

6. The professional practice performance of volunteer practitioners granted disaster privileges will be overseen by current medical staff appointees by a combination of direct observation, mentoring and concurrent clinical record review, or other appropriate mechanism developed by the Medical Staff and the Hospital.

7. A decision will be made, based on information obtained regarding the professional practice of the volunteer, related to the continuation of the disaster privileges within 72 hours of initial granting of disaster privileges. When the disaster situation no longer exists, the disaster privileges shall expire.

8. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following:

   a. the reason primary source verification could not be performed in the required time frame;

   b. evidence of the volunteer's demonstrated ability to continue to provide adequate care; and

   c. an attempt to obtain primary source verification as soon as possible.

   If a volunteer has not provided care, then primary source verification is not required.

ARTICLE X: PEER REVIEW

A. ISSUES INVOLVING MEDICAL STAFF MEMBERS

1. Options Available to Medical Staff Leaders and Hospital Administration:

   a. Medical Staff Leaders and Hospital Administration are empowered to use various options to address and resolve issues that may be raised about members of the Medical Staff. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when issues pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

      1) collegial intervention and progressive steps;

      2) ongoing and focused professional practice evaluations;

3) mandatory meeting;

4) fitness for practice evaluation (including blood and/or urine test);

5) automatic relinquishment of appointment and clinical privileges;

6) leaves of absence;

7) precautionary suspension; and

8) formal investigation.

b. In addition to these options, Medical staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g. HSHS code of conduct policy, Practitioner Health Policy, Peer Review Policy) or should be referred to the Medical Executive Committee for further action.

2. Documentation:

a. Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

b. Any documentation that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's credentials file.

3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings.

4. No Right to Counsel:

a. The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule.

b. If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

5. No Right to Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when

attending a meeting that takes place pursuant to this Article, unless agreed upon by the President of the Medical Staff.

B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

1. Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.

2. All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

3. When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

4. All ongoing and focused professional practice evaluations shall be conducted in accordance with the Medical Staff's peer review procedures. Matters that cannot be appropriately resolved through collegial intervention or through the peer review process shall be referred to the Medical Executive Committee for its review in accordance with Article XI.

C. COLLEGIAL INTERVENTION

1. These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

2. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

3. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff Members and pursuing counseling, education, and related steps, such as the following:

    a. advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

    b. proctoring, monitoring, consultation, and letters of guidance; and

    c. sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

4. The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If

documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

5. Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management. No hearing rights will be triggered by any efforts taken pursuant to this Section.

6. The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). Medical Staff leaders may also direct these matters to the Medical Executive Committee for further action.

D. ROUTINE MONITORING AND EDUCATION

The Department and/or Committee are responsible for carrying out delegated review and quality improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective for concurrent proctoring or monitoring in the course of carrying out their duties, without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the Department or Committee. Any such informal actions shall be documented in the Practitioner's file. Medical Executive Committee approval is not required for such actions; although, the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges, nor shall they be grounds for any hearing or appeal rights under Article XII.

E. VOLUNTARY REMEDIATION

1. Voluntary remediation may be appropriate when a problem or potential problem, though cause for concern, may or may not constitute grounds for formal corrective action and is of such a nature that voluntary measures can be taken to resolve it. Nothing in this Article, however, limits or restricts in any way the taking of corrective action at any time when warranted, nor shall voluntary remediation be interpreted as a mandatory first step or pre-condition to taking corrective action.

2. Voluntary remediation is an authorized peer review activity of the Hospital and its medical staff. It can, depending on circumstances, function through a variety of ways, including but not limited to, informal interviews between a practitioner with the President of the Medical Staff/designee and/or the Medical Executive Committee. It may involve the use of outside consultants, reviewers, medical practitioners, counselors, therapists, mediators, and monitors. Those participating in voluntary remediation shall be deemed agents of the Hospital. Voluntary remediation sessions shall not constitute a formal corrective action hearing. Voluntary remediation sessions, those participating in them, and the data presented are considered to be peer review protected by the confidentiality and immunity provisions under these Bylaws, as well as by Federal and State law.

3. Voluntary remediation may be requested by a Department Chairman, President of the Medical Staff, Medical Executive Committee, Governing Board or Hospital CEO.

4. Voluntary remediation, which may include but is not limited to, education, training, monitoring, psychiatric and/or medical evaluation, counseling, treatment, or therapy, may be continued, as

warranted, with the goal, if reason exists, of having the practitioner voluntarily sign a remedial action plan that outlines what steps that practitioner needs to take to remedy the problem. The remedial action plan may also contain language providing for corrective action if the terms of the voluntary remedial action plan are violated.

5. A copy of the remedial action plan shall be kept in the practitioner's credentialing file. It shall not be disclosed or released to any party without written authorization by the practitioner, unless disclosure is required by applicable law.

6. Because voluntary remediation does not constitute a professional review activity as described by the Health Care Quality Improvement Act of 1986, it shall not be deemed a reportable event to the State Medical Board or to the National Practitioner's Data Bank.

F. FITNESS FOR PRACTICE EVALUATION

1. An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.

2. A request for an evaluation may be made of an applicant by the Credentials Committee or Practitioner Health Committee during the initial appointment process or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

3. The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual will all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional(s) to discuss and report the results to the Medical Staff Leaders or relevant committee.

4. Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges.

ARTICLE XI: CORRECTIVE ACTION

A. PROCEDURE FOR VOLUNTARY RELINQUISHMENT OF CLINICAL PRIVILEGES

1. Request to Relinquish Clinical Privileges:

   a. A Medical Staff Member who desires to voluntarily relinquish any one or more of the clinical privileges granted at any time during the appointment period may submit a written request to the Chief Executive Officer specifying the clinical privilege(s) to be relinquished. This request will be transmitted by the Chief Executive Officer to the Credentials Committee and by it to the appropriate Department Chairperson. Thereafter, it will be reviewed in the same manner as a request for increase in clinical privileges, or as a part of the reappointment application if the request is made at that time. The relinquishment of privileges shall not be effective until acknowledged in writing by the Board.

b. The procedure set forth in this Section shall not apply to situations where the Member has been deemed by the Hospital to have automatically relinquished privileges pursuant to these bylaws, rules and regulations or the Hospital bylaws or policies.

c. In addition, voluntary relinquishment of clinical privileges while under investigation or in return for not conducting an investigation shall be considered a "surrender" of such privileges and shall be so reported when required.

B. COLLEGIAL INTERVENTION INVESTIGATIONS

1. Initial Review:

   a. Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

      1) the clinical competence or clinical practice of any Medical Staff appointee, including the care, treatment or management of a patient or patients;

      2) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the Bylaws, policies, or Rules or Regulations of the Hospital or its Board or Medical Staff, including, but not limited to the Hospital's quality assurance, risk management, and utilization review programs;

      3) behavior or conduct on the part of any Medical Staff Member that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the Member to work harmoniously with others the matter may be referred to the President of the Medical Staff, the Chairperson of a Clinical Department, the chairperson of a standing committee, the Chief Executive Officer, or the Chairperson of the Board; or

      4) any other matter concerning an appointee’s qualifications.

   b. The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Medical Executive Committee.

   c. No action taken pursuant to this Section shall constitute an investigation.

2. Initiation of Investigation:

   a. When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the code of conduct policy or the physician practitioner health policy), or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.

b. The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

c. The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

d. The President of the Medical Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

3. Investigative Procedure:

a. Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, or podiatrist).

b. The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

c. The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

d. The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is

not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

e. The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

f. At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.

g. In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committees may consider:

1) relevant literature and clinical practice guidelines, as appropriate;

2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

3) any information or explanations provided by the individual under review.

4. Recommendation:

a. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:

1) recommend that no action is justified;

2) issue a letter of guidance or counsel;

3) issue a written warning or reprimand;
4) impose conditions for continued appointment;

5) impose a requirement for monitoring or consultation;

6) recommend additional training or education;

7) recommend reduction of clinical privileges;

8) recommend suspension of clinical privileges for a term;

9) recommend revocation of appointment and/or clinical privileges; or

10) make such other recommendations as it deems necessary or appropriate.

b. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by the Medical Staff leaders on an ongoing basis through the performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

c. Any recommendation by the Medical Executive Committee that would entitle the affected individual to the procedural rights provided in Article VII 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 his right to a hearing as provided in Article XII. 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 or his designee shall be available to the Board or its appropriate Committee to answer any questions that may be raised with respect to the recommendation.

d. If the action of the Medical Executive Committee does not entitle the individual to a hearing in accordance with Article XII, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore shall be made to the Board through the Chief Executive Officer and the action shall stand unless modified by the Board.

e. 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 Article XII, 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 provided in Article XII.

C. PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

1. Grounds for Precautionary Suspension:

a. Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the President of the Medical Staff, the Chairperson of a Department, the Chairperson of the Credentials Committee, the CEO, CPE or Chairman of the Governing Board shall each have the authority to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation, or (2) suspend or restrict all or any portion of the clinical privileges of a Medical Staff Member or other individual.

b. A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

c. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

d. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the President of the Medical Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

e. When possible, prior to the imposition of a precautionary suspension or restriction, the person(s) considering the suspension or restriction will meet with the individual and review the concerns that support the suspension or restriction and afford the individual an opportunity to respond.

2. Medical Executive Committee Procedure:

a. Request for Hearing. Any individual who is the subject of a precautionary suspension or restriction may request a hearing with the Medical Executive Committee. Any such request must be made in writing within three days of the imposition of the suspension or restriction. The hearing must then be held within 15 days of the imposition of the suspension or restriction (unless the individual and the Medical Executive Committee agree upon a different time frame/schedule). Prior to the hearing, the individual shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any).

b. Scope of Hearing. The scope of any such hearing shall be limited to the appropriateness of imposing, and the need to continue, the precautionary suspension or restriction under the circumstances. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. The individual may also propose ways other than a precautionary suspension or restriction to protect patients and other individuals. Neither the suspended individual nor the Medical Executive Committee shall be accompanied by counsel at this hearing.

c. Medical Executive Committee Action. Whether or not a hearing is requested by the individual, the Medical Executive Committee shall review the information and circumstances resulting in the precautionary suspension or restriction and determine whether the action should be affirmed, lifted, or modified. The decision of the Medical Executive Committee should be made as soon as practical following the suspension or restriction, but not later than 10 days following the date of the hearing (if one is requested).

1) Affirmed. The Medical Executive Committee may affirm the precautionary suspension or restriction pending completion of a formal investigation pursuant to Article XI of these Bylaws. If, following the formal investigation, the Medical Executive Committee makes another recommendation that would entitle the practitioner to a hearing under Article XII of these Bylaws, the practitioner may request such a hearing and it will be conducted in accordance with the provisions of Article XII.

2) Lifted or Modified. If the Medical Executive Committee determines that the precautionary suspension or restriction should be lifted or modified, this decision shall

take effect immediately. The Medical Executive Committee shall then take whatever next steps are appropriate under the circumstances, which could include proceeding with a formal investigation pursuant to Article XI of these Bylaws. The Board (or a committee of the Board) shall review the Medical Executive Committee's determination to lift or modify the suspension or restriction on an expedited basis. If the Board (or committee) disagrees with the determination of the Medical Executive Committee, representatives of the Board and the Medical Executive Committee shall meet to discuss the matter and determine appropriate next steps.

3. Care of Suspended Individual's Patients:

   a. Immediately upon the imposition of a precautionary suspension, the appropriate department chairperson or a designee or, if unavailable, 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. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

   b. All Medical Staff appointees have a duty to cooperate with the President of the Medical Staff, department chairperson, Medical Executive Committee, and CEO in enforcing suspensions.

D. AUTOMATIC RELINQUISHMENT

1. Failure to Complete Medical Records:

   a. The elective and emergency admitting privileges of a Medical Staff appointee, except with respect to those patients already in the Hospital, shall be automatically relinquished for failure to complete medical records after notification of delinquency by the Medical Records Department, unless the appointee is without fault in causing the delinquency. A medical record is considered to be delinquent fourteen (14) days after discharge. Written notice of such automatic relinquishment shall be forwarded to the affected individual by mail from the appropriate clinical department chairperson through the Medical Staff Office with notification to the appropriate clinical department chairperson. Relinquishment shall continue until all the delinquent records are completed. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the date of the first notification of relinquishment shall result in automatic resignation from the Medical Staff.

   b. For the purpose of enforcing this Section, extensions may be granted for justified reasons for delay in completing medical records which shall include, but not be limited to, the following:

      1) the staff member or other individual contributing to the medical record is ill, on vacation, or otherwise unavailable for a period of time;

      2) the staff member is waiting for the results of a late report and the medical record is otherwise complete except for the discharge summary and the final diagnosis; and/or

      3) the staff member has dictated reports, including but not limited to, discharge summaries, and is waiting for transcription to be complete.

2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

a. Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria set forth in these Bylaws, must be promptly reported to the Chief Executive Officer.

b. An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license. 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 restricted.

2) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization. Whenever an individual's state or federal controlled substance certificate is subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation.

3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence against another, or (v) conversion, misappropriation of property or embezzlement; or bribery, evidence tampering, or perjury.

6) Imprisonment: Imprisonment in any state or federal prison for any period of time as a result of a conviction or pleas of guilty or no contest pertaining to any felony.

c. An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in these Bylaws, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in these Bylaws.

d. Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment shall be deemed permanent.

3. Failure to Satisfy Continuing Education Requirements:

a. Failure to complete mandated continuing education requirements shall result in automatic relinquishment of Medical Staff appointment and clinical privileges. Such failures shall be documented and specifically considered by the Credentials and Medical Executive Committees when making recommendations for reappointment and by the Board when making its final decisions.

b. Any appointee who is ineligible for reappointment for failure to satisfy continuing education requirements shall be entitled to meet with the Executive Committee of the Board before final action is taken. This meeting with the Medical Executive Committee of the Board shall not be conducted under the rules for a hearing as provided in these Bylaws.

c. If reappointment is refused by the Executive Committee of the Board, the individual shall be eligible to reapply and the application shall be processed as if it were an initial application.

4. Failure to Provide Information:

Appointment and clinical privileges shall be deemed to be automatically relinquished upon the occurrence of the following:

a. failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request by the Credentials or Medical Executive Committees or the CEO, or any other individual or committee authorized to request such information;

b. discovery of a misstatement, misrepresentation or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO to be material and without good cause after considering any written or oral explanation provided by the individual;

c. failure to notify the President of the Medical Staff or CEO of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO to be material and without good cause after considering any written or oral explanation provided by the individual; or

d. failure to undergo a blood, hair or urine test or a complete physical or mental examination if at least two Medical Staff leaders or one Medical Staff leader and the CEO or CPE are concerned about the appointee's ability to safely and competently care for patients.

Automatic relinquishment of privileges shall continue until the requested information is provided.

5. Failure to Attend Special Conference:

a. Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff leaders may require the individual to attend a special conference.

b. Special notice will be given at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

c. Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in the automatic relinquishment of all or such portion of the

individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the individual attends the special conference.

6. Failure to Comply with Request for Fitness for Practice Evaluation:

   a. Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

   b. Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

7. Reinstatement from Automatic Relinquishment and Automatic Resignation:

   a. If the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

   b. A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff.

   c. Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.

   d. All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, the Chief Physician Executive, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

   e. Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff.

8. Hearings Regarding Automatic Relinquishments:

a. Any individual who is the subject of an automatic relinquishment of appointment and/or clinical privileges may request a hearing with the Medical Executive Committee. Any such request must be made within three days of the notice of the automatic relinquishment provided to the individual. The hearing must then be held within 15 days of the date of the automatic relinquishment (unless the individual and the Medical Executive Committee agree upon a different time frame/schedule).

b. The hearing shall be governed exclusively by this Article. The provisions of Article XII of these Bylaws shall not apply to hearings related to automatic relinquishments of Medical Staff appointment and/or clinical privileges.

c. The scope of the hearing shall be limited to demonstrating that the event that led to the automatic relinquishment did not occur or that there was an extraordinary and unique circumstance that justified the event. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. Neither the individual nor the Medical Executive Committee shall be represented by counsel at this hearing. The decision of the Medical Executive Committee following the hearing shall be final, with no right of further appeal.

ARTICLE XII: HEARING AND APPEAL PROCEDURES

A. INITIATION OF HEARING

An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever a recommendation unfavorable to him has been made by the Medical Executive Committee regarding those matters enumerated in Part A, Section 1 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 any action set forth in Part A, Section 1. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether Medical Staff or Board.

1. Grounds for Hearing:

   No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

   a. denial of initial Medical Staff appointment;
   b. denial of Medical Staff reappointment;

   c. revocation of Medical Staff appointment;

   d. denial of requested initial clinical privileges;

   e. denial of requested increased clinical privileges;

   f. decrease of clinical privileges;

   g. suspension of total clinical privileges for more than 30 days;

h. imposition of mandatory concurrent consultation or prolonged proctoring requirements; or

i. denial of reinstatement from a leave of absence, or imposition of modification of privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.

2. Actions Not Grounds for a Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

a. issuance of a letter of guidance, counsel, warning, or reprimand;

b. imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

c. a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

d. automatic relinquishment of appointment or privileges (entitles the individual to the hearing rights set forth in Article XI);

e. imposition of a requirement for additional training or continuing education;

f. precautionary suspension (entitles the individual to the hearing rights set forth in Article XI);

g. denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

h. determination that an application is incomplete;

i. voluntary acceptance of a performance improvement plan option;

j. determination that an application will not be processed due to a misstatement or omission; or

k. determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

3. 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. The affected 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 CEO. In the event the affected individual does not request a Hearing within the time and in the manner hereinabove set forth, he shall be deemed to have waived his right to such a Hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

4. Notice of Hearing and Statement of Reasons:

a. The CEO shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the individual who requested the hearing. The notice shall include:

1) the time, place and date of the hearing;

2) a proposed list of witnesses, as known at that time, who will give testimony or present evidence at the hearing regarding the recommendation and a brief summary of the nature of the anticipated testimony;

3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

4) a statement of the specific reasons for the adverse recommendation including, if applicable, a list of patient records and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications. The individual and counsel shall have sufficient time, up to thirty (30) days, to study this additional information.

b. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

5. Witness List:

a. Within ten (10) days after receiving notice of the 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 the individual's behalf and shall include a brief summary of the nature of the anticipated testimony.

b. The witness list of either party may, in the discretion of the Presiding Officer or Hearing Panel Chairperson, 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. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

6. Hearing Panel, Presiding Officer, and Hearing Officer:

a. Hearing Panel: The CEO, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines: :

1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson..

2) The Hearing Panel may include any combination of:

a) any member of the Medical Staff, or
b) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

5) The Hearing Panel will not include any individual who:

a) is in direct economic competition with the individual requesting the hearing;

b) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

c) actively participated in the matter at any previous level.

b. Presiding Officer:

1) In addition to a Hearing Panel, the Chief Executive Officer shall also appoint a Presiding Officer who shall be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

2) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

3) The Presiding Officer shall:

a) allow the participants in the hearing to have a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

c) maintain decorum throughout the hearing;

d) determine the order of procedure;
e) rule on all questions which pertain to matters of procedure and the admissibility of evidence;

f) make certain that all information relevant to the appointment or clinical privileges of the individual requesting the hearing is presented to the Hearing Panel; and

g) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

4) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

c. Hearing Officer: As an alternative to the Hearing Panel described in paragraph (a) of this Section, the Chief Executive Officer, at his discretion and after consulting with the President of the Medical Staff (and Chairperson of the Board if the Hearing was occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law or some other individual capable of conducting the Hearing. The Hearing Officer may not be any individual who is in direct economic competition with the individual requesting the Hearing, and shall not act as a prosecuting officer or as an advocate to either side at the Hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

d. Compensation: Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may contribute to that compensation. Compensation shall not constitute grounds for challenging the impartiality of the Hearing Panel members.

e. Objections: Any objections to any Member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, or the Arbitrator, shall be made in writing, within ten days of receipt of notice, to the Chief Executive Officer. A copy of such written objections must be provided to the President of the Medical Staff and must include the basis for the objections. The President of the Medical Staff shall be given a reasonable opportunity to comment. The Chief Executive Officer shall rule on the objections and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objections.

7. Discovery:

a. There is no right to discovery in connection with the hearing. However, the affected individual shall be entitled, upon specific written request, to the following, provided that the written request must state that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual's expense;
2) reports of experts relied upon by the Executive Committee or the Board;

3) redacted copies of relevant committee or department meeting minutes (such provision is not intended to constitute a waiver of the state peer review protection statute); and

4) copies of any other documents relied upon by the Medical Executive Committee (or the Board).

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

b. The affected individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Medical Staff appointees.

c. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

d. Prior to the hearing, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the Medical Executive Committee (or the Board) copies of any expert report or other documents relied upon by the individual.

e. Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

f. Neither the Hospital nor its attorney nor any other person on behalf of the Hospital shall contact those persons appearing on the affected individual's witness list concerning the subject matter of the hearing, unless such witness is also listed as a witness for the Hospital or unless specifically agreed upon by counsel.

8. Pre-Hearing Conference:

The Presiding Officer may require counsel or other representative for the individual and for the Hospital's Executive Committee (or the Board) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer may specifically require that:

a. documentary evidence be exchanged by the parties prior to this conference and any objections to the documents be made at this conference and be resolved by the Presiding Officer;

b. evidence unrelated to the reasons for the adverse recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges be excluded;

c. any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;

d. the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

e. witnesses and documentation not provided and agreed upon in advance of the hearing shall be excluded from the hearing, except upon a showing of good cause.

9. 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 or its Chairperson on a showing of good cause.

10. 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.

B. HEARING PROCEDURE

1. Representation:

   The individual requesting the Hearing shall be entitled to be represented at the Hearing by an attorney or other person of his choice to examine witnesses and present his case. He shall inform the Chief Executive Officer in writing of the name of that person at least 10 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. The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

2. 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 and that individual requesting the Hearing equally.

3. Rights of Both Sides:

   a. At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

      1) to call and examine witnesses, to the extent they are available and willing to testify;

      2) to introduce exhibits;

      3) to cross-examine any witness on any matter relevant to the issues;

      4) representation by counsel who may call, examine, and cross-examine witnesses and present the case;

      5) to submit a written statement at the close of the hearing; and

      6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

b. Any individual requesting a hearing who does not testify in his or her own behalf may be called and questioned as if under cross-examination.

c. The Hearing Panel may question the witnesses, call additional witnesses or request additional documentary evidence.

4. Order of Presentation:

The Medical Executive Committee or the Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its adverse professional review recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

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 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.

6. Official Notice:

The presiding officer shall have the discretion to take 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 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 noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time (not to exceed 30 days) shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

7. Written Statements:

At the close of the Hearing both sides may submit a written statement to the Hearing Panel, Hearing Officer or Arbitrator summarizing the position and arguments of each.

8. Basis of Decision:

a. The Hearing Panel shall recommend in favor of the Medical Executive Committee (or the Board) unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the adverse recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial, credible evidence.

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

1) oral testimony of witnesses;

2) post-hearing statements;

3) any information regarding the individual 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;

4) any and all applications, reference evaluations, and accompanying documents;

5) medical records; and

6) any other information presented at the hearing.

9. 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 support.

b. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Medical Executive Committee or the Board unless it finds that the individual who requested the Hearing has proved that the recommendation that prompted the Hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

10. Attendance by Panel Members:

The fact that certain panel Members were not physically present at all times during the Hearing will not disqualify them or invalidate the Hearing. Consequently, no quorum of the Hearing Panel shall be required in order to continue the Hearing. The vote shall be by majority of those appointed to the Hearing Panel.

11. 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.

12. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

13. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Medical Executive Committee.

C. APPELLATE REVIEW PROCEDURE

1. Time for Appeal:

   a. Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

   b. If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

2. Grounds for Appeal:

   The grounds for appeal shall be limited to the following:

   a. There was substantial failure by the Hearing Panel to comply with these Bylaws and/or the Bylaws of the Hospital during the hearing, so as to deny a fair hearing; and/or

   b. the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

3. Time, Place and Notice:

   Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, as soon as arrangements can reasonably be made, taking into account the schedules of all participants, schedule and arrange for an appeal. The affected individual shall be given notice of the time, place and date of the appeal. When a request for an appeal is from an individual who is under a suspension, the Review Panel shall be convened not more than fourteen (14) days from the date of receipt of the request for an appeal unless the individual agrees to a longer period. The time for an appeal may be extended by the Chairperson of the Board for good cause.

4. Nature of Appellate Review:

   a. The Board may serve as the Review Panel, or the Chairman of the Board may appoint an Appellate Review Committee composed of not less than three persons, either Members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
   b. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Appellate Review Committee may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

c. The Appellate Review Committee may, in its discretion, 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 Appellate Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

D. BOARD ACTION

1. Final Decision of the Board:

   a. Within 30 days after the Board (i) considers the appeal as an Appellate Review Committee, (ii) receives a recommendation from a separate Appellate Review Committee, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

   b. The Board may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Appellate Review Committee. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

   c. The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

2. Further Review:

   Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

3. Right to One Hearing and One Appeal Only:

   No Member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current Member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE XIII: ALLIED HEALTH PROFESSIONALS

A. SCOPE AND OVERVIEW

1. These Bylaws address those allied health professionals who are permitted to practice or provide services at the Hospital and its facilities.

2. Only those classes of allied health professionals that have been approved by the Board shall be permitted to practice at the Hospital. When the Board determines that there is a need for the services of a particular type of allied health professional and decides to permit those allied health professionals to practice in the Hospital, the Board, in consultation with the Medical Staff, shall amend existing policies or adopt a separate policy that establishes the minimum qualifications that must be demonstrated by such individuals, as well as the authorized privileges or scope of practice and supervision requirements, if applicable, for those professionals in the Hospital.

3. These Bylaws set forth the credentialing processes for allied health professionals at the Hospital, as well as the general practice parameters for these individuals.

4. Current listings of the specific categories of allied health professionals functioning in the Hospital are attached to these Bylaws as Appendix A. The Appendix may be modified or supplemented by action of the Board, after receiving the recommendation of the Medical Executive Committee, without the necessity of further amendment of these Bylaws.

5. These Bylaws shall be supplemented by separate policies as references in paragraph 2 above. These separate policies shall set forth: (a) any specific qualifications and/or training that the allied health professional must possess beyond those set forth in these Bylaws; (b) a detailed description of the allied health professional's authorized clinical privileges or scope of practice; (c) any specific conditions that apply to the allied health professional's functioning within the Hospital; and (d) all supervision requirements, if applicable.

6. Process for Determining Need for a New Category of Allied Health Professionals:

    a. Whenever an allied health professional requests to practice at the Hospital and the Board has not already approved that specific category of practitioner, the CEO shall refer the matter to the Credentials Committee to evaluate the need for that specific category of allied health professionals. The Credentials Committee shall report to the Medical Executive Committee, which shall make a recommendation to the Board for final action.

    b. As part of the process of determining need, the allied health professional shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.

    c. The Credentials Committee may consider the following factors when making a recommendation as to the need for the services of a specific category of allied health professionals:

        1) the nature of the services that would be offered;

        2) any state license or regulation which outlines the specific patient care services and/or activities that the allied health professionals are authorized by law to perform;

        3) any state “nondiscrimination” or “any willing provider” laws that would apply to the allied health professionals;

        4) the patient care objectives of the Hospital, including patient convenience;

5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the allied health professionals were provided at the Hospital;

6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

7) the availability of supplies, equipment, and other necessary Hospital resources;

8) the need for, and availability of, trained staff to support the services that would be offered; and

9) the ability to appropriately supervise performance and monitor quality of care.

d. If the Credentials Committee makes a recommendation that there is a need for the particular category of allied health professionals at the Hospital, it shall also recommend:

1) any specific qualifications and/or training that must be possessed beyond those set forth in these Bylaws;

2) a detailed description of a scope of practice or clinical privileges;

3) any specific conditions that apply to practice within the Hospital; and

4) any supervision/collaboration requirements, if applicable.

e. In developing such recommendations, the Credentials Committee shall consult the appropriate clinical service chief(s) and consider relevant state law and may contact professional societies or associations. The Credentials Committee may also recommend the number of allied health professionals that are needed.

B. APPLICATION

1. General Qualifications of Applicants:

To be eligible to apply for initial and continued permission to practice, allied health professionals must, where applicable:

a. have a current, unrestricted license, certification, or registration to practice in Wisconsin and have never had a license, certification or registration to practice revoked or suspended by any state licensing agency;

b. where applicable to their practice, have a current, unrestricted DEA registration;

c. be board certified by the appropriate nationally-recognized certifying body, as applicable (AHPs credentialed prior to the approval date of these Bylaws will be grandfathered;

d. be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill responsibilities and provide timely and continuous care for patients in the Hospital;

e. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

f. have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;

g. have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

h. have never had clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned or relinquished affiliation or clinical privileges during an investigation or in exchange for not conducting an investigation;

i. have never been convicted of, or entered a plea of guilty or no contest to, any felony or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

j. satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital; and

k. if applicable, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy.

2. Factors for Evaluation:

The following factors will be evaluated, as applicable, as part of a request for permission to practice:

a. relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

b. adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients, families, and their profession;

c. ability to safely and competently perform the clinical privileges or scope of practice requested;

d. good reputation and character;

e. ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

f. recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

3. No Entitlement to Medical Staff Appointment:

   a. Allied health professionals who are applying to practice at the Hospital shall not be eligible for appointment to the Medical Staff, or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

   b. Allied health professionals shall practice at the Hospital at the discretion of the Board.

   c. Allied health professionals may attend meetings of the Medical Staff, Medical staff committees and department meetings if invited by the President of the Medical Executive Committee or the Medical Staff Departmental Chairperson.

4. Hospital Colleagues:

   Individuals who are colleagues of the Hospital shall be governed by such administrative policies, manuals, and position descriptions as established by Hospital administration for all duties performed as a colleague of the Hospital, including grievance policies. Where applicable, the CEO or a designee shall consult appropriate Medical Staff appointees including, but not limited to, department chairpersons, and/or committee chairpersons regarding the qualifications of those Hospital colleagues whose responsibilities require the delineation of clinical privileges or scope of practice.

5. Non-Discrimination Policy:

   No individual shall be denied permission to practice at the Hospital on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to professional qualifications or to the Hospital's purposes, needs and capabilities.

6. Assumption of Duties and Responsibilities:

   As a condition of consideration of an application and as a condition of continued permission to practice in the Hospital, all allied health professionals shall assume such reasonable duties and responsibilities as the Credentials Committee, Medical Executive Committee, and/or Board shall require including:

   a. providing appropriate continuous care and supervision of the generally, professionally recognized level of quality and efficiency to all patients in the Hospital for whom the individual has responsibility;

   b. abiding by all bylaws and policies of the Hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is granted permission to practice in the Hospital;

   c. attending orientation including training on the use of the electronic medical record prior to being allowed to exercise clinical privileges;

d. accepting committee assignments and such other reasonable duties and responsibilities as shall be assigned;

e. providing to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

f. appearing, if requested, for personal interviews in regard to the application;

g. abiding by the terms of the *Ethical and Religious Directives for Catholic Healthcare Services* promulgated, from time to time, by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church and to perform no activity prohibited by said Directives;

h. refraining from illegal fee splitting or other illegal inducements relating to patient referral;

i. refraining from assuming responsibility for diagnoses or care of Hospitalized patients for which he or she is not qualified or without adequate supervision;

j. refraining from deceiving patients as to his or her status as an allied health professional;

k. seeking consultation whenever necessary;

l. promptly notifying the Chief Executive Officer or a designee, and the Chairperson of the Credentials Committee of any change in eligibility for payments by third-party payers or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

m. abiding by generally recognized ethical principles applicable to the individual's profession;

n. participating in quality evaluation and performance improvement activities of the Hospital;

o. completing, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, these Bylaws and other applicable policies of the Hospital;

p. complying with all policies and requirements regarding the use of the electronic medical record;

q. working cooperatively with Medical Staff appointees, other allied health professionals, nurses and other Hospital personnel so as not to adversely affect patient care;

r. participating in applicable continuing education programs;
s. maintaining a current e-mail address with the Medical Staff Office; and

t. agreeing to immediately submit to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of administration) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership.

7. Professional Conduct:

   Allied health professionals who are granted permission to practice in the Hospital are expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital administration and personnel. Professional conduct shall also include, but not be limited to, each individual's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

8. Requests for Application:

   An application for permission to practice in the Hospital shall be given only to those classes of allied health professionals who have been approved by the Board, who meet the general qualifications set forth in these Bylaws, and have provided evidence of liability coverage levels as required by the Hospital.

   The applicant shall indicate on the request for application form or the clinical privileges or scope of practice form the specific procedures or clinical activities which the applicant desires to perform.

9. Information to be Submitted with Applications:

   a. Applications shall be submitted on a form approved by the Board upon recommendation of the Credentials and Medical Executive Committees and obtained from the Medical Staff Office. The application shall include the payment of such processing fees as may be recommended by the Medical Executive Committee and approved by the Board.

   b. The application shall contain a request for specific scope of practice and shall require detailed information concerning the applicant’s professional qualifications including:

      1) the names and complete addresses of at least two (2) physicians, dentists, podiatrists or other practitioners, as appropriate, who have had extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant’s present professional competence and character. References may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;

      2) the names and complete addresses of the individuals who served as chairpersons at the time the applicant worked in the particular department of any and all hospitals or other institutions. 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 Committee (and Medical Executive Committee) and the Board may take into consideration such factors;

      3) information as to whether the applicant’s scope of practice or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

4) information as to whether the applicant has ever voluntarily or involuntarily withdrawn an application for appointment, reappointment and scope of practice, not including a voluntary personal decision by the applicant to request a lesser scope of practice upon reappointment or during the term of appointment, or resigned before final decision by a hospital's or health care facility's governing board;

5) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted or is currently being challenged;

6) documentation concerning the applicant's current professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance coverage covers the scope of practice requested, and whether any restrictions have been imposed on the applicant's liability coverage;

7) a consent to the release of information from the applicant's present and past professional liability insurance carriers;

8) information concerning pending professional liability litigation, final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information the Credentials or Medical Executive Committees or the Board may deem appropriate;

9) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, and whether such proceedings are closed or still pending;

10) information concerning the suspension or termination for any period of time in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

11) current information regarding the applicant's ability to exercise the scope of practice requested competently and safely and to perform the duties and responsibilities of appointment;

12) information as to whether the applicant has ever been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, Medicare, Medicaid or insurance or health care fraud or abuse, or violence;

13) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

14) information on the citizenship or visa status of the applicant;

15) the applicant's signature; and

16) such other information as the Board may require.

c. The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of a scope of practice. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or a particular scope of practice. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard professional practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular scope of practice requested, or general behavior.

10. Applicant's Signature:

The applicant's signature shall constitute agreement:

a. 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, and agrees to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and scope of practice are granted;

b. that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall result in no further processing. If appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic relinquishment of the scope of practice and appointment. In either situation, there shall be no entitlement to any hearing or appeal;

c. that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;

d. authorize the release of all information necessary for an evaluation of the individual's qualifications; and

e. extend, to the fullest permitted by law, immunity to the Hospital, its Medical Staff and all individuals acting for the Hospital and/or its Medical Staff in matters relating to appointment, reappointment and clinical privileges.

11. Submission of Application:

a. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the complete application along with all supporting materials to the Credentials Committee.

b. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.

c. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be voluntarily withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

12. Burden of Providing Information:

a. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

b. The applicant shall have the burden of proving that all the statements made and information given on the application is true and correct. Any misstatement, omission and/or misrepresentation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur. In the even that allied health professional status has been granted prior to discovery of such misstatement, misrepresentation or omission, such discovery shall result in automatic relinquishment of all clinical privileges or scope of practice, and resignation from the allied health professional staff. In either situation, there will be no entitlement to the procedural rights provided in these Bylaws.

13. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for permission to practice the individual expressly accepts the following conditions:

a. Immunity: To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, or scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

b. Authorization to Obtain Information from Third Parties: The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued authorization to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

c. Authorization to Release Information to Third Parties: The individual also authorizes Hospital representatives to release information to other Hospitals, health care facilities,

managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges or scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

d. Procedural Rights: The allied health professional agrees that the procedural rights set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

e. Legal Actions: If an individual institutes legal action challenging any credentialing, privileging, or peer review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

f. Scope of Section: All of the provisions in this Section 13 are applicable in the following situations:

1) whether or not permission to practice and clinical privileges or scope of practice are granted;

2) throughout the term of any affiliation with the Hospital and thereafter;

3) should permission to practice or clinical privileges or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure at the Hospital.

C. CREDENTIALING PROCEDURE: INITIAL PERMISSION TO PRACTICE

1. Initial Review Procedure:

a. The appropriate Hospital supervisor and/or physician Department Chairperson or a designee shall examine the application and all supporting information and documentation and make a written report to the Credentials Committee regarding the applicant's qualifications for the clinical privileges or scope of practice requested. They may also meet with the applicant and the employing or supervising physician, if applicable, to discuss any aspect of the applicant's qualification to perform the privileges or scope of practice requested.

b. The Hospital supervisor and/or Department Chairperson shall be available to answer any questions that may be raised with respect to that chairperson's report and findings.

2. Credentials Committee Procedure:

a. The Credentials Committee shall review and consider the report prepared by the Hospital supervisor and/or Department Chairperson and may interview the applicant. Thereafter, the Credentials Committee shall make a recommendation.

b. After determining that an applicant is otherwise qualified for permission to practice, the Credentials Committee shall determine whether there is any question about the applicant's

ability to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental health examination by a physician(s) satisfactory to the Committee. The results of this examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

c. The Credentials Committee's recommendation shall be forwarded to the Medical Executive Committee.

3. Medical Executive Committee Procedure:

a. At its next regular meeting, after receipt of the written findings and recommendations of the Credentials Committee, the Medical Executive Committee shall:

1) adopt the findings and recommendations of the Credentials Committee; or

2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

3) state its reasons in its report and recommendation along with supporting information, for its disagreement with the Credentials Committee's recommendation.

b. If the recommendation of the Medical Executive Committee is favorable, it shall be forwarded to the Board through the President of the Medical Staff.

c. If the recommendation of the Medical Executive Committee would entitle the applicant to the procedural rights set forth in Article XIV, the Chief Executive Officer shall send the applicant special notice. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived the procedural process outlined in these Bylaws.

4. Board Action:

Upon receipt of a recommendation that the applicant be granted appointment and the scope of practice, the Board (or the Executive Committee of the Board) may:

a. appoint the applicant and grant the scope of practice as recommended; or

b. refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

c. reject or modify the recommendation. If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly notify the applicant by special notice that he or she is entitled to request a hearing.

D. CREDENTIALING PROCEDURES: CLINICAL PRIVILEGES

1. Clinical Privileges:

   The clinical privileges recommended to the Board will be based upon consideration of the following:

   a. education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;

   b. ability to perform the privileges requested competently and safely;

   c. information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

   d. adequate professional liability insurance coverage for the clinical privileges requested;

   e. the Hospital's available resources and personnel;

   f. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

   g. any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Hospital;

   h. practitioner-specific data as compared to aggregate data, when available;

   i. morbidity and mortality data, when available; and

   j. professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

E. CREDENTIALING PROCEDURES: PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

1. Submission of Application:

   a. The grant of a scope of practice or clinical privileges is a courtesy and, if granted, shall be for a period not to exceed two years. A request to renew a scope of practice or clinical privileges shall be considered only upon submission of a completed renewal application.

   b. At least three months prior to the date of expiration of an Allied Health Professional's scope of practice or clinical privileges, the Medical Staff Office shall notify the individual of the date of expiration and provide the individual with a renewal application.

   c. Failure to return a completed application at least two months prior to the expiration of the individual's scope of practice or clinical privileges shall result in automatic expiration of such scope of practice or clinical privileges at the end of the then current term.

d. Once an application for renewal of scope of practice or clinical privileges has been completed and submitted to the Medical Staff Office, it shall be evaluated following the same procedures outlined in these Bylaws regarding initial applications.

2. Renewal Process for Allied Health Professionals:

a. The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, shall be applicable in processing requests for renewal for these practitioners.

b. As part of the process for renewal of clinical privileges, the following factors shall be considered:

1) an assessment prepared by the applicable clinical Department Chairperson;

2) an assessment prepared by a peer, if possible;

3) results of the Hospital's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);

4) resolution of any verified complaints received from patients or staff; and

5) any focused professional practice evaluations.

c. In addition to the above, if applicable, the following information shall be considered:

1) an assessment prepared by the Supervising Physician(s); and

2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

F. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS

1. Supervision/Collaboration by Employing or Supervising/Collaborating Physician:

a. Any activities permitted by the Board to be done at the Hospital by an allied health professional requiring supervision/collaboration shall be done only under the supervision/collaboration of the physician employing or supervising/collaborating with that individual. Except as provided by law or Hospital policy, "supervision" shall not require the actual physical presence of the employing or supervising physician.

b. Allied health professionals requiring supervision/collaboration may function in the Hospital only so long as they remain employees of, or are supervised by or collaborating with, a physician currently appointed to the Medical Staff. All allied health professionals who are granted a scope of practice or clinical privileges at the Hospital shall be assigned to the same department as their employing or supervising/collaborating physician. Should the Medical Staff appointment or clinical privileges of the staff physician employing an allied health professional requiring supervision/collaboration be revoked or terminated, that individual's permission to practice in the Hospital shall be deemed to be automatically relinquished,

resulting in termination without the right to a hearing or meeting as provided in these Bylaws or a grievance hearing as may be provided for Hospital employees. If the Medical Staff appointment or clinical privileges of a physician supervising/collaborating with an allied health professional requiring supervision/collaboration is revoked or terminated, or if the individual's employment is terminated by the employing physician, or if supervision/collaboration is refused by the supervising/collaborating physician, the Allied Health Professionals Review Panel may immediately recommend the termination of the allied health professional's permission to practice in the Hospital, or may recommend that the individual be permitted to arrange for employment or supervision/collaboration by another physician appointed to the Medical Staff.

2. Questions Regarding Authority:

    a. Should any Medical Staff appointee who is licensed or certified by the State have any question regarding the clinical competence or authority of an AHP either to act or to issue instructions outside the physical presence of the employing, sponsoring, or supervising/collaborating Physician, that Medical Staff appointee or Hospital colleague shall have the right to require that the individual's employer or supervisor validate, either at the time or later, the instructions of the individual. Any act or instruction of the AHP may be delayed until such time as the staff appointee or Hospital colleague can be certain that the act is clearly within the scope of the individual's activities as permitted by the Board.

    b. Any question regarding the professional conduct of an AHP shall be reported to the appropriate clinical department, the Chairperson of the Credentials Committee or the President of the Medical Staff. At all times the employing, or supervising/collaborating Physician shall remain responsible for all acts of the AHP while at the Hospital.

3. Responsibilities of Employing, Sponsoring, Supervising/Collaborating Physician:

    a. The number of AHPs acting under the supervision/collaboration of one (1) physician, clinic, or group, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the regulations and policies of the Hospital, but shall not exceed four (4) AHPs at any one time.

The sponsoring practitioner shall provide oversight for the AHP, as applicable.

ARTICLE XIV: PEER REVIEW PROCEDURES FOR ALLIED HEALTH PROFESSIONALS

A. COLLEGIAL INTERVENTION

1. As part of the Hospital's performance improvement and professional practice evaluation activities, these Bylaws encourage the use of collegial efforts and progressive steps by Medical Staff leaders and administration to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.

2. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

3. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review activities.

4. The President of the Medical Staff, in conjunction with the Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., policy on practitioner health, code of conduct policy, professional practice evaluation policy) or to direct the matter to the Medical Executive Committee for further review and/or investigation.

B. INVESTIGATIONS

1. Initiation of Investigation:

    a. When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

    b. The President of the Medical Staff will keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

2. Investigative Procedure:

    a. The Medical Executive Committee shall either investigate the matter itself, request that it be conducted by the Credentials Committee, or appoint an ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the Allied Health Professional or the Allied Health Professional's Supervising Physician (where applicable).
    b. The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.

    c. The investigating committee will also have the authority to use outside consultants, if needed.

    d. The investigating committee may require a physical and/or mental examination of the individual by a health care professional(s) acceptable to it.

    e. The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Neither the investigating committee nor the individual being investigated shall have the right to be represented by legal counsel at this meeting.

    f. The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

g. At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

3. Recommendation:

a. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:

1) determine that no action is justified;

2) issue a letter of guidance, counsel, warning, or reprimand;

3) impose a requirement for monitoring, proctoring, or consultation;

4) recommend additional training or education;

5) recommend reduction of clinical privileges or scope of practice;

6) recommend suspension of clinical privileges or scope of practice for a term;

7) recommend revocation of clinical privileges or scope of practice; or

8) make any other recommendation that it deems necessary or appropriate.

b. A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The Chief Executive Officer will hold the recommendation until after the individual has completed or waived a hearing and appeal.

c. If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

d. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

C. ADMINISTRATIVE SUSPENSION

1. The Chief Executive Officer, Chief Physician Executive, Governing Board Chairman, President of the Medical Staff, and/or the appropriate Department Chairperson shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.

2. An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the President of the Medical Staff, and shall remain in effect unless or until modified by the Chief Executive Officer or the Medical Executive Committee. The imposition of an administrative suspension

does not entitle an Allied Health Professional to the procedural rights set forth in Article XIV, Section F of these Bylaws.

3. Upon receipt of notice of the imposition of an administrative suspension, the Chief Executive Officer and President of the Medical Staff shall forward the matter to the Medical Executive Committee which shall review and consider the question(s) raised and thereafter make a recommendation to the Board.

D. AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE OR CLINICAL PRIVILEGES

The scope of practice or clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in these Bylaws, in the following circumstances:

1. The Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Article XIII, Section B or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

2. the Allied Health Professional is indicted, convicted, or enters a plea of guilty or no contest to, any felony, or any misdemeanor involving (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid, or insurance or health care fraud or abuse; or (d) violence against another;

3. the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information;

4. a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional; or

5. the AHP requiring supervision fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in these Bylaws.

E. PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth for the Medical Staff in these Bylaws. Any and all rights to which Allied Health Professionals are entitled are set forth in the Allied Health Professional Article of these Bylaws.

1. Notice of Recommendation and Hearing Rights:

   a. In the event a recommendation is made by the Medical Executive Committee that an AHP not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual shall receive special notice of the recommendation. The special notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing.

b. The rights and procedures in this Section shall also apply if the Board, without a prior adverse recommendation from the Medical Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the Medical Executive Committee shall be interpreted as a reference to the Board.

c. If the AHP wants to request a hearing, the request must be in writing, directed to the Chief Executive Officer, within 30 days after receipt of written notice of the adverse recommendation.

d. The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

2. Hearing Officer:

a. If a request for a hearing is made timely, the Chief Executive Officer, in consultation with the President of the Medical Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the licensed independent or advanced dependent professional, or any competitors of the affected individual.

b. The Chief Executive Officer, in consultation with the President of the Medical Staff, shall appoint a Presiding Officer, who may be legal counsel to the Hospital. The role of the Presiding Officer shall be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer shall maintain decorum throughout the hearing.

c. As an alternative to a Hearing Committee, the Chief Executive Officer, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

3. Hearing Process:

a. A record of the hearing shall be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript shall be available at the individual's expense.

b. The hearing shall last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

c. At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The AHP shall be invited to present information to refute the reasons for the recommendation.

d. Both parties shall have the right to present witnesses. The Presiding Officer shall permit reasonable questioning of such witnesses.

e. The AHP and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel shall not call, examine, or cross-examine witnesses or present the case.

f. The AHP shall have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

g. The AHP and the Medical Executive Committee shall have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer shall establish a reasonable schedule for the submission of such memoranda.

4. Hearing Committee Report:

a. Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee shall prepare a written report and recommendation. The Hearing Committee shall forward the report and recommendation, along with all supporting information, to the Chief Executive Officer. The CEO shall send a copy of the written report and recommendation by special notice to the AHP and to the Medical Executive Committee.

b. Within ten days after notice of such recommendation, the AHP and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

c. The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with these Bylaws and/or other applicable bylaws or policies of the Hospital and/or that the recommendation was arbitrary, capricious, or not supported by substantial evidence.

d. The request for an appeal shall be delivered to the Chief Executive Officer by special notice.

e. If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information shall be forwarded to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer shall forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board shall arrange for an appeal.

5. Appellate Review:

a. An Appellate Review Committee appointed by the Chair of the Board shall consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing

Committee may be considered at the discretion of the Appellate Review Committee. This review shall be conducted within 30 days after receiving the request for appeal.

b. The AHP and the Medical Executive Committee shall each have the right to present a written statement on appeal.

c. At the sole discretion of the Appellate Review Committee, the AHP and a representative of the Medical Executive Committee may also appear personally to discuss their position.

d. Upon completion of the review, the Appellate Review Committee shall provide a report and recommendation to the full Board for action. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

e. The AHP shall receive special notice of the Board's action. A copy of the Board's final action shall also be sent to the Medical Executive Committee for information.

f. Any AHP who is denied clinical privileges at the Hospital must wait for a period of two years before reapplying for allied health professional status.

ARTICLE XV: AMENDMENTS

A. MEDICAL STAFF BYLAWS

1. Amendments to these Medical Staff Bylaws may be proposed as follows:

   a. The Medical Executive Committee may propose amendments to the Medical Staff. Along with any such proposal, the Medical Executive Committee shall make a report and recommendation to the Medical Staff that addresses the pros, cons, benefits, and risks of the proposed amendments.

   b. the Medical Staff may propose amendments directly to the Board. A copy of any such proposals shall be provided to the Chair of the Medical Executive Committee. The Committee shall make a report and recommendation to the Board that addresses the pros, cons, benefits, and risks of the proposed amendments.

2. Proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a simple majority of the votes cast by the voting medical staff at the meeting.

3. The Medical Executive Committee may present proposed amendments to the voting staff by mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 50% of the medical staff eligible to vote.

4. The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

5. All amendments shall be effective only after approval by the Board.

6. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

7. The Medical Executive Committee is authorized to act on behalf of the Medical Staff regarding amendments to the Bylaws when:

    a. Action is necessary to comply with changes in Federal and State laws that affect the Hospital;

    b. Action is necessary to comply with State licensure requirements, Joint Commission Accreditation Standards or Medicare/Medicaid Conditions of Participation.

    In such cases, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve such amendments without prior approval of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee and have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands until it is ratified by the medical staff. If there is conflict over the provisional amendment, the conflict resolution process will be implemented and, if necessary, a revised amendment will be presented to the Governing Body for action.

B. OTHER MEDICAL STAFF DOCUMENTS

1. In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, but amended in accordance with this Section.

2. An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the rules and regulations shall be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

3. The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the

provisional amendments shall stand. If there is conflict over a provisional amendment, then the process for resolving conflicts set forth below shall be implemented.

4. All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

5. Amendments to Medical Staff policies, manuals and rules and regulations may also be proposed by a petition signed by a majority of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents shall be provided to each voting member of the Medical Staff 14 days in advance of forwarding the proposed recommendation to the Medical Executive Committee. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

6. Adoption of and changes to the Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

7. The present Medical Staff Rules and Regulations 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. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

C. CONFLICT MANAGEMENT PROCESS

1. When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:
   a. proposed amendments to the Medical Staff Rules and Regulations;

   b. a new policy proposed by the Medical Executive Committee; or

   c. proposed amendments to an existing policy that is under the authority of the Medical Executive Committee:

   A special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

2. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

3. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

APPENDIX A

ALLIED HEALTH PROFESSIONALS

Those allied health professionals who may practice at St. Joseph's Hospital are as follows:

1. Psychologists;

2. Physician Assistant;
3. Certified Registered Nurse Anesthetist (CRNA);
4. Certified Nurse Midwife
5. Nurse Practitioner;
6. Surgical First Assistant;

APPENDIX B

RULES GOVERNING HISTORIES AND PHYSICAL EXAMINATIONS

1. A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration, but in all cases prior to surgery or an invasive procedure requiring anesthesia services, by an individual who has been granted privileges by the Hospital to perform histories and physicals. The scope of the medical history and physical examination will include, as pertinent:

    a. patient identification;

    b. chief complaint;

    c. history of present illness;

    d. review of systems, to include at a minimum:

        1) Cardiovascular;

        2) respiratory;

        3) gastrointestinal;

        4) neuromusculoskeletal; and

        5) skin;

    e. personal medical history, including medications and allergies;

    f. family medical history;

    g. social history, including any abuse or neglect;

    h. physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

    i. data reviewed;

    j. assessments, including problem list;

    k. plan of treatment; and

    l. if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.

    In the case of a pediatric patient, the history and physical examination report must also include:

    a. Developmental age;

    b. length or height;

    c. weight;

d. head circumference (if appropriate); and

e. immunization status.

2. If a medical history and physical examination has been performed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided the patient has been evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition. The update to the history and physical may be included as part of the pre-anesthesia assessment process.

3. When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

4. A Short-Form history and physical, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient's present clinical condition/physical findings, may be used for ambulatory or same-day procedures as approved by the Medical Executive Committee.

5. The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

6. Non-Privileged Practitioners. If a history and physical was performed within 30 days prior to admission by an individual who has not been granted clinical privileges to do so by the Hospital, it may be used as long as, at the time of admission, an individual who has been granted the appropriate privileges by the Hospital: (i) reviews the history and physical, (ii) conducts a second assessment to confirm the information and findings, (iii) updates information as needed, and (iv) signs, dates, and times the updated history and physical.

Reviewed and Revised 5/93
Reviewed and Revised 9/94
Reviewed 9/95, 9/96, 7/97, 7/98
Reviewed and Revised 7/99
Reviewed 7/00, 7/01, 7/02
Reviewed and Revised 7/03
Reviewed, 7/04, 7/05, 7/06, 7/07, 7/08
Reviewed and Revised, 3/11
Reviewed and Revised 6/12
Reviewed and Revised 1/15
Reviewed and Revised 7/16
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