



MEDICAL STAFF BYLAWS

ORGANIZATION OF THE MEDICAL STAFF

This is a single organized, self-governing Medical Staff that has overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting to the Board of Trustees. The Staff has four Services (Medicine, Emergency, Surgery/Gynecology and Obstetrics/Pediatrics). There is an Executive Committee whose functions, performed monthly, include acting on medical staff committee(s)', service(s)', and other assigned activity group(s)' reports. The Executive Committee makes recommendations to the Board of Trustees. The Medical Staff meets quarterly with one meeting designated as an annual meeting. Responsibilities of the Service Chiefs and Officers of the Staff are specified in the Medical Staff Bylaws, Rules and Regulations.

DEFINITIONS

1. Adverse Action: An action that adversely affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.
2. Allied Health Professional (AHP): An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP).
3. Board of Directors: The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and are the governing body of the Corporation (or Partnership), sometimes herein referred to as the "Directors."
4. Board of Trustees or Board: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the "governing body" as described in the standards of the Joint Commission and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.
5. Chief Executive Officer or CEO: The individual appointed by the Board of Directors (Governing Authority) to act on its behalf in the overall management of the Hospital. Whenever the word Administrator is used in these Bylaws, it shall mean the CEO.
6. Chief of Staff: A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.
7. Clinical Privileges or Privileges: The permission granted to a practitioner by the Trustees to render specific professional, diagnostic, therapeutic, medical, dental, or surgical services.
8. Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive

Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

9. Corporation: means Frankfort Hospital, Inc., in the Commonwealth of Kentucky.
10. Data Bank: The National Practitioner Data Bank implemented pursuant to the Health Care Quality Improvement Act (HCQIA).
11. Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an AHP.
12. Disruptive Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual's own ability to practice competently. Such conduct may include rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.
13. Ex Officio: Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
14. Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP/Tricare/Champus and the Veterans programs).
15. Hospital: Frankfort Hospital, Inc., d/b/a Frankfort Regional Medical Center, 299 King's Daughters Drive, Frankfort, KY 40601, a Kentucky corporation.
16. Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offence related to the provision of health care items or services and has not been reinstated in the Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.
17. Medical Executive Committee or MEC: The Executive Committee of the Medical Staff.
18. Medical Staff: The formal organization of all categories of Practitioners designated by the Board to be eligible for Medical Staff membership. The Board has determined that the categories of Practitioners eligible for Medical Staff

membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

19. Physician: an individual who is properly licensed to practice medicine in the Commonwealth of Kentucky.
20. Practitioner/Licensed Independent Practitioner (LIP): Individuals who provide direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM)
21. Prerogative: Participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee or Allied Health personnel and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Staff policies.
22. Provisional: Any staff member shall be considered provisional for at least one year (12 months).
23. Qualified Medical person or personnel ("QMP") – In addition to a physician, Qualified Medical persons may perform medical screening examinations. Individuals in the following categories who have demonstrated current competency in the performance of medical screening examinations and who are functioning within the scope of his/her license and policies of the Hospital, have been approved by the Hospital's Governing Board as Qualified Medical Personnel: ED Physician Assistants, ED Nurse Practitioners, Labor and Labor Delivery Registered Nurses for Obstetrical Patients and Nurse Midwives.
24. Special Notice: Written notification sent by certified or registered mail, return receipt requested
25. Staff Year: The period from January 1 through December 31. The reappointment period will be April 1 to March 31 two years hence.
26. Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance.

NOTE: The English language does not include a singular pronoun meaning either he or she that is equivalent to the plural pronoun they. In the absence of such a pronoun, the word he will be used throughout this text to refer to both males and females, thereby avoiding awkward construction and time wasted in trying to avoid phrasing which might be considered "sexist."

PREAMBLE

WHEREAS, Frankfort Regional Medical Center is a private corporation organized under the laws of the Commonwealth of Kentucky and not an agency or instrumentality of any state, county or federal government; and

WHEREAS, it is recognized that no practitioner shall be entitled to staff appointment and privileges at this Hospital solely by reason of education or licensure, or appointment to the staff of another hospital; and

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

WHEREAS, it is recognized that one of the aims and goals of the Staff is to attain the quality of patient care in the hospital that is achievable commensurate with resources available, that the Staff cooperate with and is subject to the ultimate authority of the Board of Directors and Trustees, and that the cooperative efforts of the Staff, Management, Trustees and the Board are necessary to fulfil the Hospital's aims and goals;

THEREFORE, the following Bylaws have been established and approved by the Board of Trustees and Staff to facilitate the aims, goals and purposes listed above.

ARTICLE I
NAME

The practitioners granted privileges to practice in the Hospital shall be collectively known as the Medical Staff or Staff of Frankfort Regional Medical Center, Frankfort, Kentucky.

ARTICLE II
PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Staff are:

- 2.1-1 To ensure that all patients admitted to, or treated in, any of the facilities, departments, or services of the Hospital shall receive the quality of patient care that is achievable commensurate with community resources available;
- 2.1-2 To serve as a primary means for accountability to the Trustees to ensure an optimal level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges and through an ongoing review and evaluation of each practitioner's performance in the Hospital;
- 2.1-3 To serve as a means of accountability and the reporting of results to the Trustees of quality improvement activities in accordance with the Hospital's quality improvement plan;
- 2.1-4 To provide an appropriate educational setting that will assist in maintaining patient care standards and that will lead to continuous advancement in professional knowledge and skill;
- 2.1-5 To initiate, maintain, and enforce rules and regulations for the proper functioning of the Staff; and
- 2.1-6 To provide a means whereby issues concerning the Staff and Hospital may be discussed by the Staff with the Board of Trustees and the CEO.

2.2 RESPONSIBILITIES

The responsibilities of the Staff are:

- 2.2-1 To account and report to the Trustees concerning quality improvement activities in the Hospital through the following:
 - (a) To assure the qualifications and competence of practitioners through a credentials procedure, including mechanisms for appointment and reappointment and the delineation of clinical privileges;

- (b) To conduct educational programs based primarily on the need demonstrated through quality improvement activities and the quality improvement program;
- (c) To review the utilization of hospital resources with attention to the requirements of the Hospital's utilization review plan;
- (d) To continually evaluate and monitor the quality of patient care;
- (e) To initiate and take appropriate corrective actions with respect to practitioners and AHPs, when warranted;
- (f) To develop and monitor compliance with the current Staff Bylaws, Rules and Regulations, and by all other lawful standards, current policies and Bylaws of the Board of Trustees;
- (g) To develop and adopt medical staff bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the Board of Trustees. These bylaws and rules and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence;
- (h) To identify community health needs and establish appropriate institutional goals;
- (i) To assist the Trustees in establishing mechanisms to assure that all patients with the same health problem are receiving the same level of care in the Hospital, to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying opportunities to improve patient care, and for identifying and resolving problems;
- (j) To participate in any Hospital deliberations affecting the performance of medical staff responsibilities, and
- (k) To exercise the authority granted by these Bylaws as necessary to adequately fulfil the foregoing responsibilities.

2.3 REPORTING

The medical staff shall take all actions necessary to assist the Trustees and the Hospital in complying with the reporting requirements of law, including HCQIA, governing professional review actions and/or disciplinary actions with respect to licensed professionals in connection with the Hospital.

2.4 OBTAINING REPORTED INFORMATION

The medical staff through the Credentials Committee will request from the Data Bank information reported under HCQIA concerning any practitioner or other person:

2.4-1 At the time he applies for staff membership or clinical privileges at the Hospital;

2.4-2 At least once every two years for each such practitioner or person who is on the Staff or has been granted clinical privileges at the Hospital; and

2.4-3 Any time a practitioner requests additional clinical privileges.

2.5 PRIVACY PRACTICES

Each member of the Medical Staff, as well every Practitioner or Allied Health Professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to a "Provider" in the paragraph), shall be in part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. 1640501, (which is commonly known as the HIPPA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for the purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admission process, which will include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

ARTICLE III.
ARTICLE THREE: APPOINTMENT/REAPPOINTMENT

3.1. NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints. Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws. No person shall admit patients or provide services to Hospital patients as a Practitioner or AHP unless he/she is appointed to the Staff or has been granted clinical privileges in accordance with the provisions outlined in these Bylaws. Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual's Staff category or as are afforded to AHPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:

3.1.1. LICENSURE

The applicant must possess a current active license in the State of Kentucky for the practice of medicine, dentistry, podiatry or an allied health practice. Proof of licensure in the form of a copy of the license shall be included as part of the application for membership. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.

3.1.2. CONTROLLED SUBSTANCE REGISTRATION

To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration. Proof of registration in the form of a copy of the registration certificate(s) shall be included as part of the application. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.

3.1.3. PROFESSIONAL EDUCATION AND TRAINING

The applicant must have graduated from an accredited School of Medicine, Dentistry, Podiatry, or school appropriate to their profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school. An applicant Practitioner must also have successfully completed a residency program in the field of specialty for which the Practitioner requests clinical privileges and shall be board certified, board qualified as defined by the specialty board for his/her specialty, or comparably qualified as defined by the Medical Executive Committee. At the time of reappointment to the Medical Staff or renewal or revision of clinical privileges, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested and requirements set forth by the Kentucky Board of Medical Licensure or appropriate board of licensure pertaining to continuing medical education requirements for relicensure. Participation in continuing education shall be considered when making decisions about clinical privileges.

3.1.4. CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Service Chairperson(s).

3.1.5. CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behaviour shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behaviour shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Service and Service Chairperson(s).

3.1.6. PROFESSIONAL ETHICS AND CHARACTER

The applicant shall agree to abide by the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant's practice if it is not listed. The applicant shall also agree to abide by the Code of Conduct of HCA, and the code of ethical business and professional behaviour of this Hospital.

3.1.7 COMMUNICATION SKILLS

The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

3.1.8. PROFESSIONAL LIABILITY INSURANCE

The applicant shall maintain professional liability insurance coverage for the clinical privileges requested with limits of at least \$1 million for each claim and \$3 million in aggregate, as a qualification for initial appointment and to cover the term of the individual's Medical Staff membership or clinical privileges (e.g., "claims-made" coverage).

3.1.9 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person.

3.1.10 HEALTH STATUS

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Credentials Committee. Upon receipt of such notification, the Credentials Committee will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Credentials Committee and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

3.2. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the Staff

review requests for Staff membership and/or particular clinical privileges in connection with appointment, reappointment or otherwise on the basis of the following:

3.2.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital.

3.2.2. EXCLUSIVE CONTRACTS

The Board may determine, in the interests of quality of patient care and as a matter of policy, that certain Hospital based clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.

3.2.3. MEDICAL STAFF DEVELOPMENT PLAN

The Board may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.

3.2.4. EFFECTS OF DECLINATION

Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges, shall not be reportable to the National Practitioner Databank and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

3.3. EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.

3.4. NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, race, religion, creed, or national origin.

3.5. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfil the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

- 3.5.1 Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;
- 3.5.2 Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Board of Trustees to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;
- 3.5.3 Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;
- 3.5.4 Abide by all local, State and Federal laws and regulations, JCAHO standards, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 3.5.5 Regularly attend meetings of the Medical Staff as outlined in Attendance Requirements.
- 3.5.6 Discharge such Medical Staff, Service, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff;
- 3.5.7 Participate in necessary training and utilize the CPCS to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;
- 3.5.8 Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
- 3.5.9 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
- 3.5.10 Participate in continuing education to maintain clinical skills and current competence.
- 3.5.11 Notify and update the Medical Staff and Hospital immediately upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining

criteria for clinical privileges (including but not limited to becoming an Ineligible Person);

3.5.12 Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate; and,

3.5.13 Perform such other responsibilities as the Hospital or the Medical Staff may require.

3.6. TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges shall be for a period of one year (12 months), and subject to extension for a total period not to exceed two years (24 months). Reappointments shall be for a period not to exceed two years (24 months). The Medical Staff Office shall provide special 30 day notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

3.7 APPLICATION

3.7.1 A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in writing or electronic, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given a copy of these Bylaws, the Medical Staff and applicable departmental Rules and Regulations, and applicable Hospital policies. At least six months prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges.

3.7.2 BURDEN ON APPLICANT

3.7.2.1 The applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-

date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities are submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Office shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Failure to provide a complete application, as defined in these Bylaws, within six months after being provided with an application form for appointment, reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Office shall provide 30 day notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application form shall include, without limitation:

- 3.7.2.1.1 Identifying information, including name, social security number, date of birth, any aliases, a passport-type photograph, any biometric identification required to verify identification or background, and addresses of office and residence.
- 3.7.2.1.2 For new applicants, evidence of citizenship in the United States of America (e.g., birth certificate showing place of birth in this country, naturalization papers, or USA passport), or evidence that the applicant is in the USA legally and has the required permission(s) to work in this country. For applicants who are not USA citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required.
- 3.7.2.1.3 Evidence of current licensure in the State of Kentucky and information regarding any current or past licensure in any healthcare profession or in any other state;

- 3.7.2.1.4 Evidence of current federal DEA certification for applicants requesting immediate prescribing privileges;
- 3.7.2.1.5 For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;
- 3.7.2.1.6 For reappointments or renewal of clinical privileges, the applicant's participation in continuing education (as required by State Licensing Board), specifically as related to the clinical privileges requested;
- 3.7.2.1.7 The names of at least two peers who will provide information as to the applicant's experience, current competence, judgment, conduct, ethics and character, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal (and therefore not a current partner in medical practice, spouse or other family member). For an applicant for reappointment, the applicant's Service Chief may serve as one of the peers, if he/she is a peer of the applicant;
- 3.7.2.1.8 Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;
- 3.7.2.1.9 Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;
- 3.7.2.1.10 Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;
- 3.7.2.1.11 Medicare Provider UPIN;
- 3.7.2.1.12 Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;
- 3.7.2.1.13 Accurate and complete disclosure with regard to the following queries:
 - 3.7.2.1.13.1 Whether the applicant's professional license or controlled substance registration in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending,

- or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;
- 3.7.2.1.13.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;
- 3.7.2.1.13.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,
- 3.7.2.1.13.4 Whether the applicant has ever been subject to a criminal conviction, as defined in these Bylaws, or whether any such action is pending.
- 3.7.2.1.14 A statement from the applicant that he/she agrees to abide by the ethical code and standards governing his/her profession;
- 3.7.2.1.15 A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.10;
- 3.7.2.1.16 Evidence that applicant has complied with health screening requirements (e.g., tuberculosis screening)
- 3.7.2.1.17 A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and Medical Staff policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and Medical Staff policies which may be duly adopted;
- 3.7.2.1.18 A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;
- 3.7.2.1.19 A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 3.1.10, and for a new applicant a permission to conduct a background check, and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.
- 3.7.2.1.20 A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.

- 3.7.2.1.21 In the case of applicants for initial appointment to the Medical Staff, a signed Medicare Acknowledgement Statement.
- 3.7.2.1.22 Physicians, other Practitioners, and Allied Health Professionals will sign an Information Security Agreement at the time of application for initial appointment, and during the reappointment process and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.
- 3.7.2.1.23 Except for applicants for Staff membership in the Honorary or Affiliate category, all applications must include a specific written request for clinical privileges using prescribed forms.
- 3.7.2.1.24 As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to provide to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, including but not limited to any change in licensure or DEA status or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.7.3 VERIFICATION PROCESS

- 3.7.3.1 Upon the receipt of a completed application form, the Medical Staff Office shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Office shall consult primary sources of information about the applicant's credentials, where feasible. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Hospital and the verification is documented. If the primary source has designated another organization as its agent in providing information to verify credentials, the Hospital may use this other organization as the designated equivalent source. The Medical Staff Office shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed; meaning that all information has been provided and verified, as defined in these Bylaws. The following information shall be verified for all applicants for appointment, reappointment, or clinical privileges, except as specified:

- 3.7.3.2 Current licensure shall be verified through the applicable state licensure boards for all applicants at the time of appointment to membership and initial granting of clinical privileges, reappointment, and at renewal of clinical privileges and at the time of expiration. For new applicants, current and past licensure in other states shall also be verified through those applicable state licensure boards.
- 3.7.3.3 For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism.
- 3.7.3.4 For new applicants, completion of medical school or other post-graduate programs appropriate to the applicant's healthcare profession shall be verified through the school's registrar's office, or the National Student Clearinghouse if designated by the school to provide degree verification, and/or through the ECFMG in the case of a foreign medical school graduate.
- 3.7.3.5 For new applicants, internship, residency, or other applicable postgraduate training shall be verified through the program's registrar's office or program director's office.
- 3.7.3.6 For new applicants, a background check shall be obtained.
- 3.7.3.7 Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.
- 3.7.3.8 The OIG Sanction Report and the GSA List shall be checked to ensure that the applicant is not listed.
- 3.7.3.9 Professional liability insurance shall be verified through the insurance carrier.
- 3.7.3.10 Data and information regarding professional performance shall be requested from available sources:
 - 3.7.3.10.1 Relevant applicant-specific data as compared to aggregate data;
 - 3.7.3.10.2 Morbidity and Mortality Data
- 3.7.3.11 The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.10, and as part of information requested from the applicant's peers, or in the case of an applicant for reappointment, from the applicant's Service Chief.
- 3.7.3.12 Letters from the applicant's peers shall be obtained. Two peer letters of reference shall be required for initial applicants. One letter of reference shall be required for applicants for reappointment or

renewal of clinical privileges; the Service Chief may serve as the second peer reference in such cases unless the Service Chief is not a peer, and then two peer references letters shall be required.

3.7.3.13 For reappointments or the renewal of clinical privileges, information regarding the applicant's number of cases, treatment results and conclusions drawn from quality assessment, performance improvement activities, and other information regarding the applicant's history of meeting the criteria for membership or clinical privileges, as defined in these Bylaws, shall be assembled for review. Relevant applicant-specific information from organization performance improvement activities shall be considered and compared to aggregate information when evaluating professional performance, judgment, and clinical or technical skills at the time of reappointment, or renewal or revision of clinical privileges. It is the responsibility of the applicant to provide this documentation as part of the reappointment application. If not provided the application will be deemed incomplete and this shall be considered an automatic resignation.

3.7.3.14 Specialty board certification shall be verified through consultation with the American Board Medical Specialties (ABMS), the American Board of Osteopathic Specialties (ABOS), the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS), or a comparable specialty board, as applicable.

3.7.3.15 With regard to new applicants for Staff membership or clinical privileges, or applicants for reappointment who are not active at the Hospital, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other facilities where the applicant is affiliated and actively practicing.

3.7.4 APPLICATION PROCESS

3.7.4.1 Service Action

The Chief of each such service shall review the application and supporting documentation. In the event that the applicant is the Service Chief or the Service Chief is absent, the Chief of Staff or the Past Chief of Staff shall make the evaluation and recommendation. The Chief of the service to which the applicant is applying, at his discretion, may conduct a personal interview with the applicant. The Chief of other services in which the applicant seeks privileges may at their discretion, request a personal interview with the applicant. They shall then transmit to the Credentials Committee on the prescribed form a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category and service, clinical privileges to be granted, and any special conditions to be attached to the appointment. A Service Chief may also recommend that the Credentials Committee defer action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation

considered by a chairperson, all of which shall be transmitted with the report. Physicians who have not had any patient contacts at the hospital for two (2) years and who have no other active hospital practice, will automatically be moved to the Affiliate Staff. Action taken under this provision is not related to patient care and there is no right to a fair hearing. In the event that the affected physician documents that this provision does not apply, the physician may be reinstated to the staff category requested on the most recent reappointment application.

3.7.4.2 Credentials Committee Action

The members of the Credentials Committee shall review the application, the supporting documentation, and such other information available to it that may be relevant to consideration of the application's qualifications for the staff category and clinical privileges requested. The Credentials Chairperson shall transmit to the MEC, on the prescribed form a written report and recommendations as to staff category and service, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Chairperson may also recommend that the MEC defer action on the application until it is complete. The reason for each recommendation shall be stated and supported by references to the completed application and all other documentation considered by the Committee, all of which shall be transmitted with the report. Any minority views shall also be submitted in writing, supported by reasons and references, and transmitted with the majority report.

3.7.4.3 Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Service Chief, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Service Chair, Credentials Committee, Medical Executive Committee or Board of Trustees.

- 3.7.4.3.1 More than three concurrent licenses to practice (e.g., license to practice in two or more other states in addition to the State of Kentucky);
- 3.7.4.3.2 Any evidence of an unusual pattern or excessive number of professional liability claims, settlements or judgements;
- 3.7.4.3.3 Inability to confirm identity;
- 3.7.4.3.4 Inability to confirm legal permission to reside and/or work in the USA;
- 3.7.4.3.5 Any other inconsistent or less than favourable information about the applicant's professional qualifications, competence or character, as judged by the Service Chair, Credentials Committee, Medical Executive Committee or Board of Trustees.

3.7.4.4 Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendations as well as any comments from the appropriate clinical service(s), the MEC shall consider the report and such other information available to it that may be relevant to the applicant's qualifications for the staff category, service and clinical privileges requested. The MEC shall then forward to the Trustees a written report and recommendations on the prescribed form as to staff appointment and, if appointment is recommended, as to staff category, service, and clinical privileges to be granted and any special conditions to be attached to the appointment. The Committee may also defer action on the application pursuant to Section 3.7.4.5 (a). Any minority views shall also be submitted in writing, supported by reasons and references, and transmitted with the majority report

3.7.4.5 Effect of Medical Executive Committee Action

(a) Deferral: Action by the MEC to defer the application for further consideration must be followed up within 30 days with a recommendation for either provisional appointment with specified clinical privileges or for rejection for staff appointment.

(b) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO shall promptly forward it, together with all supporting documentation, to the Board of Trustees. For the purposes of this Section, "all supporting documentation" includes the application form, its accompanying information, the reports and recommendations of the Credentials Committee, and report of the chairperson of the services.

(c) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO shall immediately so inform the practitioner by special notice, and he shall be entitled to the procedural rights as provided in Article VIII. The applicant shall exercise his procedural rights prior to submission of the adverse recommendation to the Trustees.

3.7.4.6 Reapplication After Adverse Appointment Decision

An applicant who has received an adverse decision regarding appointment shall not be considered for application to the Staff for a period of one year after notice of such decision is sent. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Staff or the Trustees may require in demonstration that the basis for the earlier adverse action no longer exists.

3.7.4.7 Time Periods for Processing

Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause, shall be processed within the

time periods specified in this section. The CEO shall transmit an application to the Credentials Committee upon completing his information collection and verification tasks, but in any event within 90 days after receiving the completed application. The Credentials Chairperson and Service Chairperson shall act on an application within 60 days after receiving it from the CEO. The MEC shall review the application and make its recommendation to the Trustees within 30 days after receiving the Credentials report. The Trustees shall review the application and shall then take action on the application at its next regular meeting. The Board of Trustees in accordance with the bylaws, rules and regulations, and policies of the medical staff and the Hospital, shall act on each request at its next regular meeting based on the reports, recommendations and other available information pertinent to each applicant. The decision of the Board shall be final, and notice of the decision shall be transmitted by the CEO to each appointee being considered. Initial appointments shall be for a one-year provisional period and reappointments shall be for a period of two years.

3.7.5 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, as described in Section 3.7 of this Article, at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall be reported to the Credentials Committee and actions shall be taken as provided in these Bylaws:

- (a) Current licensure;
- (b) Drug Enforcement Administration registration Professional liability insurance;
- (c) Specialty board certification, if required for membership or any of the clinical privileges granted;
- (d) and, Not excluded, debarred, or otherwise ineligible to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List and the State Exclusion List shall be checked every six months

3.7.6 PERFORMANCE PROFILING

The Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board shall direct and enforce the establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities are defined in the Hospital's Performance Improvement Plan. The Medical Staff measurement, analysis and improvement activities shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the

performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and profiling established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and departments of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity including the Health Care Quality Improvement Act. Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual's professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual's clinical performance shall also be included. The Hospital may consider quality of care by an individual through an examination of patterns of health care delivery. Profiles may be constructed for individuals or groups of individuals based on Hospital, geographic, specialty, and type of practice or other characteristics. Performance profiles, including the results of performance based measures such as patterns of treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual's:

- (a) Quality and appropriateness of patient care, including patient care outcomes;
- (b) Malpractice and professional liability experience;
- (c) Timely, legible and accurate completion of patient medical records;
- (d) Professional conduct;
- (e) Attendance and participation in Medical Staff committee and Department meetings;
- (f) Attainment and maintenance of board certification;
- (g) Maintenance of required levels of professional liability insurance coverage;
- (h) Attainment of continuing education requirements; and,
- (i) Attribution to sentinel events, medical errors or other risk occurrences.

The Board of Trustees shall be responsible for assuring the use of clinical and other measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assessment shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assessment process.

3.8 PROVISIONAL STATUS

3.8.1 Initial Appointments

Except as otherwise determined by the Trustees, all initial appointments shall be provisional and to the associate category. Each provisional appointee shall be assigned to a service where his performance shall be observed by the Chief of the Service or such Chief's designee, or may be observed by a committee of service appointees designated by the Chief, to determine his eligibility for appointment in the staff category requested by the practitioner and for exercising the clinical privileges provisionally granted. All initial appointments and renewals thereof shall remain provisional until the appointees have furnished through appropriate staff channels, to the CEO, and to the Trustees:

- (a) A statement signed by the Chief of the Service to which he is assigned that the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the Staff category to which he was provisionally appointed; and
- (b) A statement signed by the Chief of the Credentials Committee, if appointed, that the appointee has satisfactorily demonstrated his ability to exercise the clinical privileges provisionally granted to him.
- (c) If a practitioner does not have any activity at the Hospital during this provisional period, his privileges and membership shall automatically be terminated. Should they choose to keep privileges at the Hospital, it will be necessary for them to reapply.

3.8-2 Modification in Staff Category and Clinical Privileges

The MEC may recommend to the Trustees that a change in staff category of a current staff appointee or the granting of additional privileges to a current staff appointee pursuant to Section 3.12 be made provisional in accordance with procedures similar to those outlined in Section 3.6 for initial appointments.

3.8-3 Renewals At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed twelve (12) months. Advancement shall be based upon a favorable recommendation of the individual's Service Chief based on the Chief's review of the requirements in 3.8.1, and a favorable recommendation of the Credentials Committee and MEC, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the MEC and the Board, an individual's failure to complete the requirements in 3.8.1 shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws.

Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

3.9 CONTRACT PRACTITIONERS

3.9.1 QUALIFICATIONS AND SELECTION

Practitioners ("Contract Practitioners") providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or an contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges of Contract Practitioners to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement.

3.9.2 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

3.10 LEAVE OF ABSENCE

3.10-1 Leave Status

A staff appointee may obtain a voluntary leave of absence from the Staff by submitting written notice to the Chairperson of the MEC and the CEO stating the exact period of time of the leave, which may not exceed one year unless approved by the MEC and the Board of Trustees. During such leave, the member's medical staff membership and/or clinical privileges shall be suspended.

3.10-2 Termination of Leave

At least 60 days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement of his medical staff membership and/or clinical privileges by submitting a written notice to that effect to the Chief of Staff for transmittal to the

MEC. The staff appointee shall submit a written summary of his relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation to the Trustees concerning the reinstatement of the appointee's membership and privileges. Failure to request reinstatement or to provide a requested summary of activities as above provided shall result in automatic termination of medical staff membership and/or clinical privileges without right of hearing or appellate review. A request for staff appointment subsequently received from a staff appointee so terminated shall be submitted and processed in the manner specified for applications for initial appointments. If an appointee requests leave of absence status solely for the purpose of obtaining further medical training in his own or another field of practice, and not due to threatened or pending adverse action, reinstatement will become automatic upon request for same and upon providing to the MEC documentation of education or training received if the leave terminates within the normal two-year reappointment period. However, any new privileges requested will be acted upon and monitored in similar fashion as if the appointee were a new applicant. Reinstatement will be automatic if leave of absence is for serving armed services commitment, if the leave terminates within the normal two-year reappointment period.

If a leave of absence extends beyond two years from the date of last reappointment, all practitioners on leave must complete a reappointment application during the reappointment period. If a practitioner is unable to comply, they must reapply at the end of their leave.

An adverse decision regarding reinstatement of staff membership or renewal of any clinical privileges held prior to the leave shall entitle the practitioner to a fair hearing and appeal as provided in these Bylaws.

3.11 IMPAIRED PRACTITIONER

The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges. The process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An "Impaired Individual" is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

3.11.1 SELF-REPORTING

3.11.1.1 During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change. An oral or preferably, a written report shall be given to anyone or all of the following: the Chief Executive Officer, the Chief of Staff, the Chief of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Medical Executive Committee.

3.11.1.2 THIRD PARTY REPORTS

3.11.1.2.1 If a Medical Staff member, Allied Health Professional, or Hospital employee witnesses warning signs of impairment they should report the incident. Patients, family members, or others who witness warning signs of impairment shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting signs of impairment shall be kept confidential. Medical Staff members and others, as appropriate, shall be educated about illness and impairment recognition issues specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.11.1.2.2 An oral or, preferably, a written report shall be given to anyone or all of the following: the Chief Executive Officer, the Chief of Staff, the Chief of the individual's Medical Staff Service, and/or the Chairperson of the Credentials Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may be impaired. The person making the report does not need to

have proof of the impairment, but must state the facts leading to the concern.

3.11.1.2.3 If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:

3.11.1.2.4 Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,

3.11.1.2.5 Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Peer Review Committee

3.11.1.3 INVESTIGATION

3.11.1.3.1 Following a written request to investigate, the Peer Review Committee shall investigate the concerns raised and any and all incidents that led to the belief that the individual may be impaired. The Committee's investigation may include, but is not limited to, any of the following:

3.11.1.3.1.1 A review of any and all documents or other materials relevant to the investigation;

3.11.1.3.1.2 Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the individual's health status are related to the performance of the individual's clinical privileges and Medical Staff duties and are consistent with proper patient care or the operations of the Hospital;

3.11.1.3.1.3 A requirement that the individual under investigation undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the individual's clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital, with the results of the examination to be provided to the Committee;

3.11.1.3.1.4 A requirement that the individual under investigation undergo urine drug screening, serum alcohol/drug level testing or other appropriate testing, with

the results of the screening and/or testing to be provided to the Committee.

3.11.1.3.1.5 The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the individual's clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the Committee feels that the individual may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.11.1.4 OUTCOME OF INVESTIGATION

3.11.1.4.1 Based on all of the information it reviews as part of its investigation, the Peer Review Committee shall determine:

3.11.1.4.2 Whether the individual is impaired, or what other problem, if any, is affecting the individual under investigation;

3.11.1.4.3 If the individual is impaired, the nature of the impairment and whether it is classified as a disability;

3.11.1.4.4 If the individual's impairment is a disability, whether a reasonable accommodation can be made for the individual's impairment such that, with the reasonable accommodation, the impaired individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;

3.11.1.4.5 Whether a reasonable accommodation would create an undue hardship upon the Hospital,

such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,

- 3.11.1.4.6 Whether the impairment could negatively impact the quality of care or the health or safety of the impaired individual, patients, Hospital employees, physicians or others within the Hospital.
- 3.11.1.4.7 If the Committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the impaired individual, so long as that arrangement would neither impose an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer shall be kept informed of attempts to work out a voluntary agreement before it becomes final and effective.
- 3.11.1.4.8 If the Committee determines that there is no reasonable accommodation that can be made as described above, or if the Committee cannot reach a voluntary agreement with the impaired individual, the Medical Executive Committee shall make a recommendation and report to the Board of Trustees, as appropriate to the action to be taken. If the Committee's recommendation would provide the impaired individual with a right to a hearing as described in the Medical Staff Bylaws, the impaired individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Eight of the Medical Staff Bylaws.
- 3.11.1.4.9 The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual's credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee.

3.11.1.4.10 Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.11.1.5 TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

3.11.1.5.1 If it is determined that the individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.11.1.5.2 An individual with an impairment shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological impairment such that the condition is under sufficient control.

3.11.1.5.3 The Medical Staff is not required to extend membership or privileges to an individual with an impairment, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.11.1.5.4 Upon sufficient proof that the individual who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired individual for reinstatement of Medical Staff membership or clinical privileges.

3.11.1.5.5 In considering an impaired individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

3.11.1.5.6 The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual's medical or psychological treatment. The impaired individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:

3.11.1.5.6.1 Whether the impaired individual is participating in the program or treatment;

- 3.11.1.5.6.2 Whether the impaired individual is in compliance with all of the terms of the program or treatment plan;
- 3.11.1.5.6.3 Whether the impaired individual attends AA/NA meetings regularly (if appropriate);
- 3.11.1.5.6.4 To what extent the impaired individual's behavior and conduct are monitored;
- 3.11.1.5.6.5 Whether, in the opinion of the treating physician, the impaired individual is rehabilitated or the medical/psychological impairment is under control;
- 3.11.1.5.6.6 Whether an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,
- 3.11.1.5.6.7 Whether, in the opinion of the treating physician, the impaired individual is capable of resuming practice and providing continuous, competent care to patients.
- 3.11.1.5.7 The Medical Staff has the right to require opinion(s) from other physician consultants of its choice.
- 3.11.1.5.8 Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
 - 3.11.1.5.8.1 The impaired individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
 - 3.11.1.5.8.2 The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.
 - 3.11.1.5.8.3 The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or

designee, the Chief of Staff, the Chairperson of the Credentials Committee, or the pertinent Service Chief.

- 3.11.1.5.8.4 As a condition of reinstatement, the impaired individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three of these Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.
- 3.11.1.5.8.5 If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.
- 3.11.1.5.8.6 If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.
- 3.11.1.5.8.7 All requests for information concerning the impaired individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law,

ethical obligation or when the safety of a patient is threatened.

3.12 REQUESTS FOR MODIFICATION OF APPOINTMENT

A Staff appointee may, either in connection with reappointment or at any other time, request modification of his staff category, service assignment or clinical privileges by submitting a written request to the CEO. Such request shall be processed in the same manner as provided for reappointment. No staff appointee may seek modification of privileges, staff category or service assignment previously denied on initial appointment or reappointment unless supported by the additional training and experience stated in Section 6.2.

ARTICLE IV
CATEGORIES OF THE STAFF

4.1 CATEGORIES

The staff shall include Active, Associate, Courtesy, Affiliate, and Honorary.

4.2 ACTIVE STAFF

4.2-1 Qualifications

The Active Staff shall consist of practitioners, each of whom:

- (a) Meets the basic qualifications set forth in Sections 3.1 and 3.8;
- (b) Whose office and residence are within reasonable distance from the Hospital in order to provide continuous care to his patients; (Exceptions to this must be approved by the MEC and Board of Trustees); and
- (c) Regularly admits patients to, or is otherwise regularly involved in the care of patients in, the Hospital.

4.2-2 Prerogatives

The prerogatives of an Active Staff appointee shall be to:

- (a) Admit patients without limitation, unless otherwise provided in the Staff Bylaws, Rules and Regulations, or state law;
- (b) Exercise such clinical privileges as are granted to him pursuant to Article VI;
- (c) Vote on all matters presented at general and special meetings of the Staff and of the service and committees of which he is an appointee;
- (d) Participate in various staff, service or committee functions as appointed;
- (f) Chair a medical staff service or committee office if elected.

4.2-3 Responsibilities

Each appointee of the Active Staff shall:

- (a) Meet the basic responsibilities set forth in Section 3.5;
- (b) Retain responsibility within his area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative (practitioner with comparable privileges or adequate skills) for such care and supervision;

- (c) Actively participate in the quality assessment, performance improvement and peer review activities required of the Staff, in supervising provisional appointees where appropriate, in emergency service coverage, and in discharging such other staff functions as may be required from time to time; and
- (d) Satisfy the requirements set forth in Article XII for attendance at meetings of the Staff and of the service or committees of which he is appointed.

4.3 ASSOCIATE STAFF

4.3-1 Qualifications

The Associate Staff shall consist of practitioners serving in a provisional status, each of whom:

- (a) Is assigned to a clinical service and his performance shall be observed and evaluated by the service chairman or his designee to determine his eligibility for advancement to Active Staff.
- (b) Is eligible for advancement to Active staff category and will, in the ordinary course of events and unless he requests otherwise, be advanced to Active status after serving one year on the Associate Staff. This period may be extended for up to one year but no less than six months on the recommendation of the chief of the service if there has not been adequate opportunity to observe his professional performance due to lack of utilization of the Hospital or care of a sufficient number of patients. Any decision to extend the period for appointment to the Associate Staff shall not be deemed to be adverse action involving the Associate Staff member and shall not entitle him to the procedures afforded by Article VIII.
- (c) After completion of the period for Associate Staff membership, the appointee shall be advanced to Active Staff status in which case his clinical privileges shall no longer be provisional in nature; or his appointment and privileges shall be terminated.
- (d) Associate Staff appointees shall not be eligible to hold a medical staff office or be a Chief of Service.
- (e) Meets the qualifications specified in Sections 3.1 and 4.2-1 for appointees of the Active Staff.

4.3-2 Prerogatives

The prerogatives of an Associate Staff appointee shall be to:

- (a) Admit patients to the Hospital under the same conditions as specified in Section 4.2-2 (a) for Active Staff appointees;
- (b) Exercise such clinical privileges as are granted to him pursuant to Article VI;
- (c) Vote on all matters presented at Medical Staff and service and committee meetings of which he is appointed; and
- (d)

4.3-3 Responsibilities

Each appointee of the Associate Staff shall be required to discharge the same responsibilities as those specified in Section 4.2-3 for appointees to the Active Staff. Failure to fulfil those responsibilities shall be grounds for termination of clinical privileges or denial of reappointment.

4.4 COURTESY STAFF

4.4-1 Qualifications

The Courtesy Staff shall consist of practitioners, each of whom:

- (a) Meets the basic qualifications set forth in Section 3.1; and
- (b) Who shall not admit more than 20 patients per year to the Hospital or perform more than 20 inpatient or outpatient procedures per year or perform more than 20 invasive diagnostic procedures per year.
- (c) Courtesy Staff appointees shall not be eligible to hold office, vote, or be a Chief of Service.

4.4-2 Prerogatives

The prerogatives of a Courtesy Staff appointee shall be to:

- (a) Admit patients to the Hospital within the limitations provided in Section 4.4-1.
- (b) Exercise such clinical privileges as are granted to him pursuant to Article VI; and
- (c) Attend meetings of the Staff and the service of which he is an appointee and any Staff or Hospital education programs.

4.4-3 Responsibilities

Each appointee of the Courtesy Staff shall be required to discharge the basic responsibilities specified in Section 3.5 and, further, shall retain responsibility within his area of professional competence for the continuous care and supervision of each patient in the Hospital

for whom he is providing services. Courtesy Staff shall not be responsible for serving on the specialty call roster in the Emergency Department.

4.5 AFFILIATE STAFF

4.5-1 Qualifications

The Affiliate Staff shall consist of practitioners who share the same common interests of the Medical Staff and the Board of Trustees for community health, quality patient care, and other aims and goals of the professionals in other staff categories, but are not themselves able to fulfill the criteria to be on the staff in any listed categories. These are practitioners who have office practices and maintain good professional standings, but do not wish to have clinical privileges to manage patients in a hospital setting, but desire affiliation with the Medical Staff and Hospital through Medical Staff membership. The Affiliate Staff member shall not be eligible to hold office or have voting privileges.

4.5-2 Prerogatives

Members appointed to the Affiliate Staff may:

- a) Refer patients for outpatient diagnostic testing and specialty services provided by the hospital.
- b) Refer patients for treatment by a member of the Medical Staff who has admitting privileges.
- c) Visit, review medical records and discuss the care with the attending physician of their established patients. Appointees to this category may not write inpatient orders, progress notes, actively participate in the direct provision of patient care, or perform or assist in surgery.
- d) Attend meetings of the Medical Staff, be a non-voting member of the assigned Service and participate in any educational offerings.
- e) Apply for clinical privileges by completing the process as outlined in Article III of these Bylaws.

4.5-3 Responsibilities

Affiliate Staff members are required to reapply for membership every two (2) years. The required documentation will include an application, verification of current licensure, DEA registration, proof of liability insurance, NPDB check, current TB skin test, and eligibility to participate in federal programs.

4.6 HONORARY STAFF

4.6-1 Qualifications

The Honorary Staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences or their previous longstanding service to the Hospital. Honorary Staff appointees shall not be eligible to vote or to hold office.

4.6-2 Prerogatives

Honorary Staff appointees are not eligible to admit patients to the Hospital nor to exercise clinical privileges in the Hospital. They may attend Staff and service meetings and any Staff or Hospital education meetings.

4.6-3 Responsibilities

Each member of the Honorary Staff shall abide by these bylaws and other policies and rules of the Hospital and abide by the ethical principles governing practitioners.

4.8 MEDICAL STUDENTS, INTERNS, RESIDENTS, AND FELLOWS

- 4.8.1 The terms, “medical students,” “interns,” “residents,” and “fellows,” (hereinafter referred to collectively as “house staff”) as used in these Bylaws, refer to Practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. The school or program shall provide a written description of the role, responsibilities, and patient care activities of participants in the training program. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:
- 4.8.2 4.8.1 Applicable provisions of the professional licensure requirements of this State;
- 4.8.3 A written affiliation agreement between the Hospital and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a house staff Practitioner, in the amount of \$1 million for each claim and \$3 million in aggregate; and,
- 4.8.4 The protocols established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a house staff Practitioner’s authority, mechanisms for the direction and supervision of a house staff Practitioner, and other conditions imposed upon a house staff Practitioner by this Hospital or the Medical Staff.
- 4.8.5 While functioning in the Hospital, house staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the CEO or the Chief of Staff. House staff Practitioners may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the

supervision and direction of a member of the Medical Staff. House staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Divisions, or committees, but shall have no voting rights.

4.8.6 The Medical Education Committee shall be responsible for overseeing house staff Practitioners and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs.

4.8.7 As defined in Section 4.9 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., “moonlighting” or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.9 LIMITATION OF PREROGATIVES

4.9.1 The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff appointment, by other sections of these Bylaws, and by other policies or agreements of the Hospital.

ARTICLE V.
ALLIED HEALTH PROFESSIONALS

5.1 DEFINITION

The Allied Health Professional Staff (AHP) shall be composed of individuals other than physicians, dentists, oral/maxillofacial surgeons and podiatrists who exercise independent judgment within the areas of individual professional competence and who are qualified to render patient care services in accordance with specific delineated privileges granted. Allied Health Professionals will not be considered members of the Medical Staff, but they will be assigned to a Medical Staff clinical service and their activities will be monitored by that clinical service. AHP's include, but shall not be limited to, medical assistants, physician's assistants, nurse practitioners, chiropractors, psychologists, and CRNA's. AHP's shall be under the overall supervision of the Chief of Service to which they have been assigned. Any physician requesting a consultation by an AHP shall maintain overall medical responsibility for the patient.

5.2 QUALIFICATIONS

Only an Allied Health Professional holding a license, certificate or such other credentials as may be required by the applicable state law or by the applicable licensing or certifying agency of his specialty, and who meet certain criteria, including, but not limited to:

- (a) document their qualifications, status, clinical duties, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate that they can exercise judgment within their area of competence, provided that a physician appointee of the staff shall have the ultimate responsibility for medical care; that they may participate in the management of patients under the direct supervision or direction of an appointee of the staff; and that they are qualified to provide a needed service within the Hospital;
- (b) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others;
- (c) agree to carry out their activities subject to service policies and procedures and in conformity with these Bylaws, rules and regulations;
- (d) satisfies such other criteria as established by the appropriate Medical Staff service in which he has requested privileges; shall be eligible for appointment as an allied health professional;
- (e) demonstrate that they are able to perform all or part of the medical history and physical examination, if granted such privileges; and
- (f) agree to have all findings, conclusions, and assessment of risk confirmed or endorsed by a qualified physician prior to major high-risk diagnostic or therapeutic interventions.

5.3 MEDICAL ASSISTANTS

- (a) The Board of Trustees shall examine, pass upon, limit and delineate the scope of activities within the Hospital of medical assistants (MA's) who are licensed or certified and who provide services as employees of the Hospital or physicians who are presently appointed to the Staff. The Credentials Committee shall be responsible for this task.
- (b) In certain instances, others, not possessing legal credentials or license, but who through experience, on the job training, etc., have proven capable of assisting a physician may do so on a specific limited basis. Specific reference is made to physician office staff who may assist in surgery after receiving training in sterile technique.
- (c) No such individual shall provide patient services in the Hospital as an employee of a physician appointed to the Staff or as an employee of the Hospital until and unless the Credentials Committee has received, on a form provided by the Hospital, sufficient information about the qualifications of that individual to permit the Credentials Committee to determine the scope of activities the individual will be permitted to undertake in the Hospital in compliance with applicable state and federal law. The form shall be prepared by the individual's physician employer or the MA if employed by the Hospital and signed by both the employer and the individual. Each MA shall be insured in amounts determined appropriate by the Board of Trustees and the physician employer.
- (d) The Credentials Committee shall make a written recommendation of the scope of activities each MA is permitted to undertake in the Hospital. The scope of the MA's activities shall be approved by the MEC and Trustees. It shall entitle the MA to act in the Hospital only so long as the MA shall remain an employee of the Hospital or a physician currently appointed to the Staff of the Hospital.
- (e) It shall be clearly understood that any activities permitted by the Trustees to be done in the Hospital by Medical Assistants shall be under the supervision of a physician appointee of the staff, and any and all other requirements required by the Board.
- (f) The number of Medical Assistants acting under the supervision of a physician as well as the acts they may undertake shall be consistent with the applicable state statutes and regulations.

5.4 PHYSICIAN ASSISTANT

- (a) The physician Assistant (PA) is a person qualified by academic and clinical training to provide patient services under the supervision and responsibility of a Doctor of Medicine or Osteopathy who is, in turn, responsible for the performance of the PA. Prior to the granting of the clinical privileges, the supervising physician shall provide evidence to the medical staff that the PA is qualified to practice his profession under appropriate state law. A physician shall not supervise a PA without being approved by the Kentucky Board of Medical Licensure. The Medical

Board may impose restrictions on the scope of practice of a particular physician assistant or on the methods of supervision employed by the supervising physician as it deems appropriate. Physicians must obtain specific approval for each PA they wish to supervise and the Medical Board will not approve any physician to supervise more than two (2) PA's at any one (1) time.

- (b) The Hospital Medical Staff shall examine, pass upon, limit and delineate the scope of activities within the Hospital of Physician Assistants (PA's) who are licensed or certified and who provide services as employees of the Hospital or physicians who are presently appointed to the Staff upon approval of the MEC and Board. The Credentials Committee shall be responsible for this task.
- (c) No such individual shall provide patient services in the Hospital as an employee of a physician appointed to the Staff until and unless the Credentials Committee has received, on a form provided by the Hospital, sufficient information about the qualifications of the individual to permit the Credentials Committee to determine the scope of activities the individual will be permitted to undertake in the Hospital in compliance with the applicable state and federal law and the requirements of the Board of Trustees. The form shall be prepared by the individual's physician employer and signed by both the employer and the individual. If an alternate physician agrees to supervise a PA, he must also sign the application. Each PA shall be insured in amounts determined appropriate by the Board of Trustees and the physician employer.
- (d) The Credentials Committee shall make a written recommendation of the scope of activities each PA is permitted to undertake in the Hospital. The scope of the PA's activities shall be approved by the Trustees. It shall entitle the PA to act in the Hospital only so long as the PA shall remain an employee of a physician currently appointed to the Staff of the Hospital.
- (e) It shall be clearly understood that any activities permitted by the Trustees to be done in the Hospital by PA's shall be under the direct and immediate supervision of a physician appointee of the Staff.
- (f) The number of PA's acting under the supervision of a physician as well as the acts they may undertake shall be consistent with the applicable state statutes and regulations.
- (g) PA rounds are not intended and should not be used to replace required rounds by the attending physician.

5.5 NURSE PRACTITIONER

- (a) The Nurse Practitioner (NP) is a person qualified by academic and clinical training to provide patient services under the supervision and responsibility of a Doctor of Medicine or Osteopathy who is, in turn, responsible for the performance of the NP. Prior to the granting of the hospital privileges, the supervising physician shall provide evidence to the Medical Staff that the NP is qualified to practice his profession under appropriate state law.
- (b) The Board of Trustees shall examine, pass upon, limit and delineate the scope of activities within the Hospital of NP's who are licensed and who provide services as employees of the Hospital or physicians who are presently appointed to the Staff. The Credentials Committee shall be responsible for this task.
- (c) No such individual shall provide patient services in the Hospital as an employee of a physician appointed to the Staff or until and unless the Credentials Committee has received, on a form provided by the Hospital, sufficient information about the qualifications of that individual to permit the Credentials Committee to determine the scope of activities the individual will be permitted to undertake in the Hospital in compliance with applicable state and federal law. The recommendation will have to be approved by the MEC and the Board. The form shall be prepared by the individual's physician employer or the NP and signed by both the employer and the individual. If an alternate physician agrees to supervise a NP, he must also sign the application. Each NP shall be insured in amounts determined appropriate by the Board of Trustees and the physician employer.

5.6 GRANTING OF PRIVILEGES

The extent to which an Allied Health Care Professional identified in Section 5.1 and 5.2 above may participate in direct patient care shall be reviewed and approved by the Medical Staff in accordance with the following procedure. The scope of patient care privileges being requested shall be specifically delineated in writing and shall be related to the professional's experience and current capability. This request for privileges, to be submitted on a form prescribed by the Medical Staff and Hospital, shall be submitted to the appropriate Medical Staff service by a practitioner member of the Medical Staff who is familiar with the AHP's capabilities. The Medical Staff Service shall make an appropriate recommendation to the Credentials Committee. The hospital shall check that the practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List. The request shall then be processed in accordance with the privilege granting process described in Article VI. of these Bylaws.

5.7 REAPPOINTMENT

The privileges granted to all Allied Health Professionals under this Article V. will be subject to renewal following the same procedures set forth for members of the Medical Staff in Article III of these Bylaws.

5.8 PREROGATIVES

The prerogatives of an AHP shall be to:

- (a) attend designated Medical Staff service meetings and Medical Staff service meetings and Medical Staff committee meetings (as non-voting members), upon request; and
- (b) exercise such other prerogatives as shall, by resolution or written policy duly adopted by the Staff or by any of its services or committees and approved by the MEC and the Trustees, be accorded to the AHP's as a group or to any specific category of AHP's.

5.9 RESPONSIBILITIES

The responsibilities of an AHP shall be to:

- (a) retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital to whom he is providing services;
- (b) provide the Hospital annually with proof of continuing education as specified in Section 6.7;
- (c) make entries in the medical record that relate to clinical privileges that have been granted, consistent with the requirements specified in the Medical Staff Rules and Regulations, or, as written in position description developed for a particular group of Allied Health Professionals;
- (d) participate in appropriate quality assessment and performance improvement activities required of the staff, and in discharging other staff functions as may be required from time to time;
- (e) abide by all applicable Hospital and Medical Staff Bylaws, rules and regulations;
- (f) be restricted to the specific clinical privileges permitted by state law and as recommended by the Medical Staff and approved by the Board of Trustees,
- (g) maintain professional liability insurance in such amounts as may be determined by the Board of Trustees.

5.10 LIMITATIONS

The granting of clinical privileges to one or more categories of AHP's or specified professionals within those categories, will be dependent, in the opinion of the Governing Body, on the Hospital's ability to provide facilities for the conduct of such Allied Health Professional's practice.

ARTICLE VI.

DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every practitioner or other professional providing clinical services at this Hospital by virtue of his Staff appointment or otherwise, shall, in connection with such practice and except as provided in Section 6.5, be entitled to exercise only those clinical privileges or specified services specifically granted to him by the Trustees. The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Service. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Service Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2.1 Description of Initial Clinical Privileges

Each practitioner who has been granted an appointment to the Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Trustees. The clinical privileges recommended to the Trustees shall be based upon the applicant's documented experience, education, training, past professional performance, clinical/technical skills, demonstrated competence and judgment, references and other relevant information, including an appraisal by the clinical service in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competence to exercise the clinical privileges he requests.

6.2.2 Requests

Each application for appointment and reappointment to the Staff must contain a request for hospital specific categories of clinical privileges desired by the applicant. A request by a Staff appointee for a modification of privileges must be supported by documentation of training, experience and current competence supportive of the request.

Whenever an applicant requests or currently holds clinical privileges that are relevant to the care provided in more than one service,

these clinical privileges are reviewed by each Service Chief for appropriateness and recommendation.

6.2.3 Basis for Privileges Determinations

Requests for clinical privileges shall be evaluated on the basis of the practitioner's documented experience, education, training, performance, demonstrated current competence and judgment. The basis for privileges determinations to be made in connection with periodic reappointment or otherwise shall include documentation of observed clinical performance, the documented results of patient care evaluation, outcomes, and quality assurance activities required by these Bylaws and the Hospital Bylaws. Clinical privileges granted or modified on initial appointment, reappointment or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges, National Practitioners Data Bank and the State Licensure Board.

6.2.4 Procedure

All requests for clinical privileges shall be evaluated and may be granted, modified or denied pursuant to, and as part of, the procedures outlined in Article III.

6.3 TEMPORARY PRIVILEGES

6.3.1 Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, to fulfil an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

6.3.2 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this state, a current and unrestricted DEA registration, evidence of the ability to perform the privileges requested, current competence related to the temporary privileges requested, and documentation of professional liability insurance coverage as required by the Board, except as specified in Section 6.4.4 in this Article. Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the

Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN, and the Hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, service rules and regulations, and applicable Hospital policies.

6.4.3 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from the appropriate Chief of Service or Chief of Staff (Credential Chairman in the absence of either) under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the Service Chief to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

6.4.4 Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article Six, Section 6.4.1 may be granted temporary while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days. An applicant waiting for processing of an application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application that raises no concerns and only under the following conditions:

6.4.4.1 There are no current or previously successful challenges to licensure or registration;

6.4.4.2 There are no adverse membership actions at another hospital; and

6.4.4.3 There are no adverse actions against the applicant's privileges at another hospital.

6.4.4.4 There are no pending actions against the applicant's membership or privileges at another hospital.

- 6.4.5 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article Six, Section 6.4-1 may be granted temporary privileges if the Practitioner has a specific skill not possessed by a privileged Practitioner, and the specific skill is needed by a specific patient, authorization may be granted to provide care for that specific patient. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever is less. A Practitioner may be granted temporary privileges under this condition for no more than two patients in a twelve-month period. After a Practitioner has been granted temporary privileges under this condition for the care of a second patient within twelve months, he/she shall be invited to apply for Medical Staff membership.
- 6.4.6 Locum Tenens: Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article Six, Section 6.4.2, who has been hired to substitute or supplement for a member of the Medical Staff who is temporarily unable to provide services, may be granted temporary privileges in order to fulfil an important patient care need that would be created by the Medical Staff member's absence and could not otherwise be met by the existing members of the Medical Staff. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days or the term of absence of the Medical Staff member, whichever is less.
- 6.4.7 Disaster Response and Recovery: Potential disaster situations shall be described in the Hospital Emergency Management Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital's Emergency Management Plan, temporary disaster privileges may be granted to an appropriately qualified Practitioner qualified as described in Article Six, Section 6.4-2, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges should be approved by the Hospital Emergency Incident Commander (CEO/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Incident Command System (HEICS), upon recommendation by the Chief of Staff or the HEICS-designated

Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing. The Chief of Staff or the HEICS-designated Medical Staff Director shall also assign a member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 6.5, a Practitioner would be permitted to provide patient care using emergency privileges.

6.4.7.1 Disaster privileges may be granted to volunteers considered to act as licensed independent practitioners in the organization upon presentation 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:

- 6.4.7.1.1 A current hospital ID card that clearly identifies professional designation;
- 6.4.7.1.2 A current license to practice in the State of Kentucky, and a valid picture ID issued by a state, federal or regulatory agency
- 6.4.7.1.3 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized federal organizations or groups.
- 6.4.7.1.4
- 6.4.7.1.5 Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by federal, state, or municipal entity) Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as

a licensed independent practitioner during a disaster.

- 6.4.7.2 In dire circumstances the Hospital Emergency Incident Commander (CEO/designee) or the Operations Chief shall have the right and responsibility to grant temporary disaster privileges at their discretion, irrespective of the above qualification verification. The following order of preference should be used in granting temporary disaster privileges:
 - 6.4.7.2.1 Expert Practitioners from government agencies and medical staff members from other HCA hospitals;
 - 6.4.7.2.2 Volunteer Practitioners sent from known agencies (e.g., American Red Cross);
 - 6.4.7.2.3 Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
 - 6.4.7.2.4 Volunteers from the community or surrounding areas.
- 6.4.7.3 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.
- 6.4.7.4 Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff member if possible, with whom to collaborate in the care of disaster victims.
- 6.4.7.5 In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.
- 6.4.7.6 The organization shall make a decision, based on information regarding professional practice of the volunteer, within 72 hours, related to the continuation of the disaster privileges initially granted.

6.5 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency longer exists, care of the patient shall be assigned to a Medical Staff

6.6 TELEMEDICINE

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Frankfort Regional Medical Center patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services

through the normal credentialing process. Because of the nature of the telemedicine profession and the extreme number of hospital affiliations, only (5) random hospitals will be queried for affiliations. The telemedicine practitioners will not be required to have a TB Skin Test or photo identification as these physicians are never on campus or physically provide services to our patients.

6.7 CONTINUING EDUCATION

All individuals with delineated clinical privileges must participate in continuing education which is relevant to the practitioner's specialty or whenever there are findings of performance-improvement activities which indicate a need for education or training. Participation in these continuing educational programs must be documented. When hospital sponsored educational activities are offered, they are related to the type and nature of care offered by the hospital. Continuing education is considered in decisions about reappointment to the medical staff or renewal or revision of individual clinical privileges. All practitioners must abide by the requirements set forth by the Kentucky Board of Medical Licensure or appropriate board of licensure pertaining to continuing medical education requirements for relicensure.

ARTICLE VII
CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

7.1-2 Criteria For Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief or Staff, appropriate Service Chief, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or to deal with the matter in accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity or conduct that gave rise to the request. The investigation shall be conducted pursuant to the peer review provisions in these Bylaws.

7.1-3 Alternatives to Corrective Action

a. Collegial efforts should be made prior to resorting to formal corrective action, with the exception of those infractions noted under summary and automatic suspension. Informal discussions or formal meetings with the individual involved regarding the concerns raised about conduct or performance shall take place before other collegial interventions are taken. Such collegial interventions on the part of Medical Staff leaders and CEO in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws. Collegial actions will not become part of the permanent record.

b. Alternatives to corrective action may include:

Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

Suggestion or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

Requirements suggestion to seek assistance for impairment, as provided in these Bylaws.

- 7.1-4 If the individual involved doesn't agree with the warning, the individual may write a letter of response that will be filed with the warning.

7.2 SUMMARY SUSPENSION

7.2-1 Criteria and Initiation

Whenever a Staff member's conduct or the conduct of an individual with clinical privileges appears to require that immediate action be taken to protect the life or well-being of a patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the health or safety of any patient, prospective patient, or other person, any two (2) of the following, the Chief of Staff, appropriate Service Chief, or Chief Executive Officer may impose a summary suspension or restriction on the clinical privileges of the individual. If due to time urgency and only one of the above listed is available, one (1) (Chief of Staff, appropriate Service Chief, or Chief Executive Officer or designee) may impose a summary suspension but must notify one of the above listed individuals immediately (not greater than (2) hours) that summary suspension has been imposed. If two (2) of the above listed individuals do not agree on summary suspension, the MEC shall convene within 24 hours. Unless otherwise stated, such suspension or restriction shall become effective immediately upon imposition, and the person responsible for imposing the suspension or restriction shall give written notice to the CEO and MEC within 24 hours. In addition, the affected individual shall be provided with a written notice of the action within one day of imposition. This initial notice shall include a summary of facts and issues regarding the individual's conduct that led to the summary suspension or restriction, and shall not substitute for the notice required in Article Eight. When the individual being suspended or restricted is a Practitioner, the Chief of Staff or the

Service Chief of the Practitioner's Department shall arrange for alternative medical coverage of a suspended Practitioner's patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Allied Health Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

7.2-2 Medical Executive Committee Action

Upon notice of a summary suspension or restriction, the Medical Executive Committee shall direct that an Investigation be conducted within fourteen (14) days as provided in Article Eight, of these Bylaws. The Medical Executive Committee shall also review the circumstances leading to the summary suspension or restriction and shall determine, as a result of the review, to continue, modify, or terminate/reverse the summary suspension or restriction pending the outcome of the investigation. The practitioner shall be notified of the determination within 24 hours.

7.2-3 Investigation/Peer Review Process

Peer review may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The Medical Executive Committee or the Board of Trustees may request an investigation. The Medical Executive Committee may conduct such an investigation, or the Medical Executive Committee may assign the task to a Medical Staff officer, Service Chief, ad hoc committee or other organizational component. External third parties may be utilized in the investigation process as provided in these Bylaws. The investigation may involve an interview with the practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing. The investigation shall include:

- a. Conformance to the peer review procedures.
- b. As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;
- c. A report of the investigation, including all material evidence, and a recommendation to the Medical Executive Committee.

7.2-4 Action on Investigation Report

As soon as practicable after the conclusion of an investigation, the Medical Executive Committee or the Board shall:

- a. Determine that corrective action is not warranted and dismiss the matter;
- b. Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in paragraph of these Bylaws; or,
- c. Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Eight.

7.3 AUTOMATIC SUSPENSION OR TERMINATION

7.3-1 Criteria for Action

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the CEO, and his/her staff membership may be automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice. The Chief Executive Officer shall also notify the Chief of Staff and Hospital staff members, and take necessary steps to enforce the suspension. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

7.3-1.1 LICENSURE

If an individual's license to practice is revoked or suspended by a state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her staff membership shall be automatically terminated.

7.3-1.2 CONTROLLED SUBSTANCE REGISTRATION

If an individual's DEA registration is revoked, suspended, or restricted, or if an individual fails to maintain a current unrestricted registration, he/she may be limited from practicing in the Hospital. The individual's prescribing privileges for the

schedule(s) of drugs affected by the restrictions on the DEA. registration shall be immediately automatically suspended.

7.3-3 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital. If the loss of professional liability has occurred through, an inability of the individual to obtain reasonable coverage, automatic suspension will not take place until the circumstances for the loss of coverage is reviewed by the CEO and Chief of Staff.

7.3-4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital:

a. Becoming an Ineligible Person,

Upon notifying the Chief of Staff or CEO that they have become an ineligible person as specified in Article III of the Bylaws, an emergency joint meeting of the Medical Executive Committee and Board of Trustees will convene to evaluate the ineligible issue.

b. A criminal conviction.

7.3-5 MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual's delinquent records are completed.

7.3-6 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, the individual's membership and clinical privileges shall be automatically terminated. The individual may not re-apply until twenty-four months have passed.

7.3-7 CRIMINAL ARREST

In the event that an individual is arrested for alleged criminal acts, an immediate investigation into the circumstances of the arrest shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective

action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Eight.

7.3-8 AUTOMATIC RESIGNATION

A. RELOCATION

Unless otherwise approved by the Board upon recommendation of the Medical Executive Committee, any member of the staff or other individual with clinical privileges who takes up permanent residence more than 50 miles for Active Staff or 100 miles for Courtesy from the Hospital shall be deemed to have resigned from the Staff and relinquished all clinical privileges.

B. FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated.

7.4 PROBATION

When a practitioner's license has been restricted or conditions imposed by a preliminary or final decision of the State Licensing Board or other governmental agency, or, his privileges have been restricted or terminated by a preliminary or final decision at another hospital, or his privileges have been restricted or placed under observation at this Hospital as to result of corrective action, the practitioner may be placed in a probationary subcategory of his applicable membership category. If imposed, such probationary status shall be effective for the period of time co-terminus with the period of time set by the State Licensing Board or other governmental agency or other hospital as long as any corrective action is taken. Medical staff members on probation must abide by the specifications outlined regarding their probation and will not be eligible for emergency care coverage, or to hold office or vote, or to serve on a standing committee of the medical staff. Their eligibility to participate in medical staff-sponsored services will be governed by the rules and regulations of the particular medical staff sponsored service or program. Failure of the practitioner to comply with the terms of his probation may be cause for termination of the practitioner's medical staff membership.

7.5 REPORT OF CORRECTIVE ACTION TO GOVERNMENTAL AGENCIES

After final determination of corrective action to be instituted against the practitioner, and, provided the practitioner has exercised all his rights to review, hearing, and/or appeal under the terms of these Bylaws, the Chief Executive Officer shall be responsible to report to the appropriate federal,

state and local authorities the corrective action imposed upon the practitioner, consistent with applicable rules, regulations and laws.

7.6 IMMUNITY

In all matters relating to corrective action, disciplinary proceedings, investigations, medical review or peer review, utilization review, hearings and appellate reviews, there shall be no monetary liability on the part of and no cause of action for damages shall arise against any member of the Medical Staff or other practitioners, or appropriate Hospital personnel, including members of the Board of Trustees and hospital management, for any act or proceedings undertaken or performed within the scope of the functions of any duly appointed or elected board, committee, or other group or entity, in which he or she may participate as a member respecting corrective action, disciplinary proceedings, investigations, medical or peer review, or utilization review, if any such person acts without actual malice or fraud.

ARTICLE VIII
HEARING AND APPELLATE REVIEW PROCEDURE

8.1 Right to a Hearing and to Appellate Review

8.1-1 When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Trustees, will adversely affect his appointment to or status as a member of the Medical Staff for his exercise of clinical privileges, or is summarily suspended from the exercise of his or her clinical privileges or from the Medical Staff or more than fourteen (14) days under Article VII, he shall be entitled, at his or her option, to:

(1) the arbitration of the decision pursuant to the Arbitration Procedure set forth in Appendix A,

(2) a hearing before a hearing officer appointed by the Chief Executive Officer, or

(3) a hearing before a hearing panel. If arbitration is not chosen, and such hearing, whether before a hearing officer or hearing panel, does not result in a favorable recommendation, the affected practitioner shall then be entitled to an appellate review by the Trustees before the Trustees make a final decision on the matter.

8.1-2 When any practitioner receives notice of a decision by the Trustees that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing and appellate review, he shall be entitled, at his or her option, to:

(1) the arbitration of the decision pursuant to the Arbitration Procedure set forth in Appendix A,

(2) a hearing before a hearing officer selected by the Chief Executive Officer, or

(3) a hearing by a committee appointed by the Trustees. If arbitration is not chosen, and such hearing does not result in a favorable recommendation, the affected practitioner shall then be entitled to an appellate review by the Trustees, before the Trustees make a final decision on the matter.

8.1-3 Decisions and/or recommendations which would adversely affect the practitioner's appointment to or status as a member of the Medical Staff or his exercise of clinical privileges shall include,

(1) denial of requested clinical privileges,

(2) a denial of Medical Staff privileges,

(3) denial of advancement to the Active Medical Staff,

- (4) denial of reappointment to the Medical Staff,
- (5) revocation or suspension of clinical privileges,
- (6) decrease in clinical privileges,
- (7) withdrawal of Medical Staff appointment, or
- (8) suspension of all clinical privileges or suspension from the Medical Staff for a period of fourteen (14) days or more.

8.1-4 With the exception of those matters which are arbitrated in accordance with the Arbitration Procedure set forth in Section 8.3 of this Article and Appendix A, all hearings and appellate reviews shall be conducted in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he is entitled.

8.2 Request for Hearing

8.2-1 The Chief Executive Officer shall be responsible for giving prompt formal written notice of an adverse recommendation or decision to any affected practitioner who is entitled to arbitration, a hearing before a hearing officer or a hearing panel or to an appellate review, by certified mail, return receipt requested. This notice shall include: (a) that the professional review action has been proposed to be taken, (b) the reason for the proposed action, (c) that the physician may request a hearing or an arbitration, (d) that the physician must request the hearing within 30 days from the date of notice, and (e) a summary of the rights afforded to the affected practitioner at the hearing.

8.2-2 The failure of a practitioner to request in writing, arbitration or a hearing to which he is entitled by these Bylaws within thirty (30) days after receipt of a formal written notice of an adverse recommendation or decision shall be deemed a waiver of his right to such arbitration or hearing to which he might otherwise have been entitled on the matter. Failure of the practitioner to request an appellate review to which he is entitled by these Bylaws within the time and manner herein provided shall be deemed a waiver of his right to such appellate review on the matter. In the absence of a written request by the affected practitioner for arbitration or a hearing before a hearing officer or hearing panel as outlined hereunder, the adverse recommendation or decision shall be a full, final and complete determination of the rights of the affected practitioner.

8.2-3 When the waived arbitration, hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing committee appointed by the Trustees, such adverse recommendation or decision shall thereupon be a full, final and complete determination of the rights of the affected practitioner.

In any of such events, the chief executive officer shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

8.3 Election of Arbitration

When any practitioner receives notice of a recommendation of the Executive Committee or of the Trustees that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges as set forth in 8.1-1 and 8.1-2 of this Article, including a notice of summary suspension for more than fourteen (14) days, he or she may elect to arbitrate the matter by notifying the Chief Executive Officer within thirty (30) days after receipt of an adverse recommendation or decision of his intention to arbitrate same in accord with the Arbitration Procedure set forth in Appendix A. The election made by the practitioner to arbitrate the matter shall be the exclusive means of proceeding, and the result thereof shall be final even to the extent of barring any and all litigation respecting the outcome as provided in the Arbitration Procedure set forth in Appendix A.

8.4 Election of Hearing Before a Hearing Officer or Hearing Panel

When any practitioner receives notice of a recommendation of the Executive Committee or of the Trustees that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges as set forth in 8.1-1 and 8.1-2 of this Article, including a notice of summary suspension for more than fourteen (14) days, he or she may elect to have the matter heard before a hearing officer or hearing panel by notifying the Chief Executive Officer of the fact-finding process he or she desires within thirty (30) days after receipt of an adverse recommendation or decision of his intention to proceed before a hearing officer or hearing panel in accord with this Article. The election made by the practitioner of the form of the fact-finding process shall be the exclusive means of proceedings, and the result thereof shall be final as set forth in this Article.

8.5 Notice of Hearing

8.5-1 Within ten (10) days after receipt of a request for a hearing before a hearing officer or a hearing panel from a practitioner entitled to the same, the Executive Committee or the Trustees, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days from the date of the receipt of such practitioner's request for hearing; however, when the practitioner requesting the hearing is under a summary suspension which is then in effect, such hearing shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than thirty (30) days from the date of receipt of such notice.

- 8.5-2 The notice of hearing shall state in concise language the specific acts or omissions with which the practitioner is charged, including where applicable, a list of specific or representative charts being questioned and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

8.6 Selection of Hearing Officer and Composition of Hearing Committee

- 8.6-1 When a hearing relates to an adverse recommendation of either the Executive Committee, the Trustees, or summary suspension such hearing shall be conducted by a hearing officer selected by the Chief Executive Officer who is not in direct economic competition with the affected practitioner if elected by the affected practitioner or before a panel of individuals who are appointed by the Chief Executive Officer and who are not in direct economic competition with the affected practitioner, one of the members of which shall be designated as chairman (if elected by the affected practitioner). No Medical Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of a hearing panel.
- 8.6-2 If a hearing officer is requested by the affected practitioner, the Chief Executive Officer shall select an individual, preferably a licensed attorney who is not legal counsel to the Hospital, employed on a full or part-time basis by the Hospital or Medical Staff and who is capable of conducting the hearing.
- 8.6-3 If a hearing panel is requested by the affected practitioner, the Chief Executive Officer, after considering the recommendations of the Chief of Staff and the Chairman of the Board of Trustees, shall appoint a hearing panel of not less than three (3) persons, at least one of whom must be a physician. Whereas knowledge by the individual panel member of the matter being considered does not necessarily preclude his or her appointment to the hearing panel, Medical Staff members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the hearing panel. A chairman of the hearing panel shall be named by the Chief Executive Officer at the time the hearing panel is constituted.

8.7 Conduct of Hearing

- 8.7-1 The hearing officer or all members of the hearing panel (whichever shall be chosen by the affected practitioner) shall be present when the hearing takes place; no member of the hearing panel (if such is chosen by the affected practitioner) may vote by proxy. Reason for any delay due to absence shall be documented in the minutes by the hearing officer or by the hearing panel.
- 8.7-2 An accurate record of the hearing must be kept. The mechanism shall be established by the hearing officer or hearing panel

(whichever is chosen by the affected practitioner), and may be accomplished by the use of a court reporter, electronic recording unit or detailed transcription. The record and the costs associated therewith shall be provided by the Hospital; however, the cost of any transcript copies shall be born by the party requesting such transcript.

- 8.7-3 The personal presence of the practitioner for whom the hearing is scheduled shall be required. The practitioner who fails without good cause to appear and proceed at such a hearing shall be deemed to have voluntarily waived his rights in the same manner as provided in Section 8.2 of this Article and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 8.2.
- 8.7-4 Postponement of any hearing beyond the time set forth in these Bylaws shall be made only with the approval of the hearing officer or hearing panel (whichever shall be chosen by the affected practitioner). Granting of such postponements shall only be for good cause shown in the sole discretion of the hearing officer or hearing panel.
- 8.7-5 Either a hearing officer, if one is chosen by the affected practitioner, or the chairman of the hearing panel or his designee, shall preside over the hearing to determine the order or procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- 8.7-6 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal actions. The practitioner for whom the hearing is being held shall be entitled to submit memoranda concerning any issue or procedure of fact prior to or during the hearing, and such memoranda shall be come a part of the hearing record.
- 8.7-7 The Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member or an attorney to represent it at the hearing, to present the facts in support of the adverse recommendation, and to examine witnesses. The Trustees, when their action has prompted the hearing, shall appoint one of their members or an attorney to represent them at the hearing, to present the facts in support of their adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision. The affected practitioner shall thereafter be responsible for rebutting the evidence introduced

to the end of showing that the charges or grounds involved are arbitrary, capricious, or not supported by the evidence.

- 8.7-8 The Executive Committee or Trustees and the affected practitioner shall have the following rights:
- (1) to call and examine witnesses,
 - (2) to introduce written evidence,
 - (3) to cross-examine any witness on any matter relevant to the issue of a hearing, and
- to challenge any witness and to rebut any evidence. If the practitioner does not testify on his own behalf, he may be called and examined as if under cross-examination, to present a written or oral statement at the close of the hearing.
- 8.7-9 Though the hearing provided for in these Bylaws is for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct, both the affected practitioner and the Executive Committee of the Medical Staff or the Trustees, may be represented at any phase of the hearing procedure by an attorney-at-law or other person.
- 8.7-10 The hearing officer or the hearing panel (whichever is chosen by the affected practitioner) may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing officer or hearing panel, may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.
- 8.7-11 Within thirty (30) days after final adjournment of the hearing, the hearing officer or hearing panel (whichever is chosen by the affected practitioner) shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Trustees, depending upon which body's initial recommendation has the subject of the hearing. Copies of the written report and recommendation shall be forwarded to the affected practitioner and to the Chief Executive Officer. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Trustees. Thereafter, the procedure to be followed is that provided in Section 8.8 of this Article of these Bylaws.

8.8 Appeal to the Trustees

- 8.8-1 Within ten (10) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made after a hearing as above provided, he may, by formal written notice delivered to the Chief Executive Officer by certified mail, return

receipt requested, request an appellate review by the Trustees. Such notice should specify the basis for the request for an appellate review and may request that the appellate review be held only on the record of which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

- 8.8-2 If such appellate review is not requested within ten (10) days, the affected practitioner shall be deemed to have waived his rights to the same, and to have accepted such adverse recommendation or decision, the same shall become effective immediately as provided in Section 8.3 of this Article. The affected physician's failure to make a request for appellate review in the specified period of time shall result in the adverse recommendation or decision being a full, final and complete determination of the rights of affected practitioner.
- 8.8-3 Within ten (10) days after receipt of such notice of request for appellate review, the Trustees shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than thirty (30) days from the date of receipt of the notice of request for appellate review. However, when the practitioner requesting the review is under a suspension, such review shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than thirty (30) days from the date of receipt of such notice.
- 8.8-4 The appellate review shall be conducted by the Trustees or by a duly appointed appellate review committee of the Trustees of not less than three (3) members.
- 8.8-5 The affected practitioner shall have access to the report and record (and transcription, if any) of the hearing officer or hearing panel and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. The affected practitioner shall be responsible for the costs of any transcript copies provided to him. He shall have at least thirty (30) days from the date of receipt of notice of the adverse recommendation or decision in which to submit a written statement on his own behalf in which he outlines those factual and procedural matters with which he disagrees and his reasons for such disagreement. This written statement may cover any matters raised at any step in procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Trustees through the Chief Executive Officer by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or

by the chairman of the hearing committee appointed by the Board of Trustees, and, if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least five (5) days prior to date of such appellate review by certified mail, return receipt requested.

- 8.8-6 The Trustees or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements or other documentary evidence, if any, submitted pursuant Section 8.7-2 of this Article of these Bylaws for the purpose of determining whether the adverse recommendation or decision against the affected practitioner is proper and in substantial compliance with the procedures under the Bylaws, Rules and Regulations of the Medical Staff and Trustees. The reviewing body shall determine whether the decision was supported by substantial evidence on the record or by any new evidence provided which could not have been made available at the hearing state through due diligence and/or cross-examination. If oral argument is requested as part of the procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendations or decisions and shall answer questions put to him by any member of the appellate review body. The Executive Committee or the Trustees, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.
- 8.8-7 New or additional matters not raised during the original hearing, or in the hearing committee report or not otherwise reflected in the record, shall only be introduced at the appellate review in the event such new evidence could not have been made available at the hearing stage through due diligence and/or cross-examination. The Trustees or committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.
- 8.8-8 If the appellate review is conducted by the Trustees, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation within twenty (20) days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing with respect to the disputed issues.
- 8.8-9 If the appellate review is conducted by a committee of the Trustees, such committee shall within twenty (20) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Trustees approve, modify or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within twenty (20) days. Such referral may include a request that the Executive Committee of the

Medical Staff arrange for a further hearing to resolve disputed issues. Within ten (10) days after receipt of such recommendations or referral, the committee shall make its recommendation to the Trustees as above provided.

8.8-10 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 8.8 of this Article of these Bylaws have been completed or waived. Where permitted by the Hospital bylaws, all action required of the Trustees may be taken by a committee of the Board of Trustees duly authorized to act.

8.9 Final Decision by Trustees

- 8.9-1 Within fifteen (15) days after the conclusion of the appellate review, the Trustees shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last such recommendation, the Trustees shall refer the matter to the joint conference committee for further review and recommendation within twenty (20) days, and shall include in such notice of its decision a statement that a final decision will not be made until the joint conference committee's recommendation has been received. At its next meeting after the joint conference committee's recommendation has been received, the Trustees shall make its final decision with like effect and notice as first above provided in this Section 8.8 of this Article of these Bylaws. The final decision regarding matters referred to the joint conference committee shall remain solely with the Trustees.
- 8.9-2 Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee of the Medical Staff or by the Trustees, or by a duly authorized committee of the Trustees, or by both.

ARTICLE IX.
STAFF CLINICAL SERVICES

9.1 Organization of the Medical Staff

The Medical Staff at Frankfort Regional Medical Center meets quarterly beginning in January to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care, clinical and non-clinical process provided in the Hospital. The Medical Staff is divided into clinical services.

9.2 Assignment to Services

Each appointee of the Staff shall be assigned to one principal Service, but may be granted clinical privileges in one or more of the other Services. The exercise of clinical privileges within any Service shall be relevant to the care provided in that service and subject to these Bylaws, Rules and Regulations and the authority of the Service Chairperson.

9.2-1 Surgery/Gynecology Service

Applicants to the Surgery/Gynecology Service at this Hospital shall have the following qualifications:

- a) Certified by the American Board in the respective specialty for which the privileges are granted; or
- b) Formal training in the said specialty acceptable for qualification for examination by the American Board. Membership in the service so granted shall be reviewed by the Surgery/Gynecology Service if certification has not been accomplished by the applicant within three (3) years from the date membership was granted; or
- c) If the physician does not meet the above qualifications, the Credentials Committee shall review the physician's credentials file and submit their recommendations to the MEC for action. The MEC shall evaluate the Credentials Committee recommendation and shall make a recommendation for approval or denial.

9.2-2 Medicine Service

Applicants to the Medicine Service at this Hospital shall have the following qualifications:

- a) Family Practice (General Practice): Satisfactory completion of family practice residency or one (1) year of an approved internship; (It will be policy to assign Family Practitioners to the Medicine Service and grant privileges in other Services as requested and approved through the normal credentialing process); or

b) Certified by the American Board in the respective specialty for which privileges are granted; or

c) Formal training in the said specialty and qualification for examination by the American Board of Medicine. Membership in the service so granted shall be reviewed by the Medicine Service if certification has not been accomplished by the applicant within three (3) years from the date the membership was granted; or

d) If the physician does not meet the above qualifications, the Credentials Committee shall review the physician's credentials file and submit their recommendations to the MEC for action. The MEC shall evaluate the Credentials Committee recommendation and shall make a recommendation for approval or denial.

9.2-3 Pediatrics/Obstetrics Service

Applicants to the Pediatric/Obstetrics Service at this Hospital shall have the following qualifications:

a) Certified by the American Board in the respective specialty for which privileges are granted; or

b) Formal training in the said specialty and qualification for examination by the American Board of Pediatrics. Membership in the service so granted shall be reviewed by the Pediatrics/Obstetrics Service if certification has not been accomplished by the applicant within three (3) years from the date membership was granted.

If the physician does not meet the above qualifications, the Credentials Committee shall review the physician's credentials file and submit their recommendations to the MEC for action. The MEC shall evaluate the Credentials Committee recommendation and shall make a recommendation for approval or denial.

9.2-4 Emergency Service

Applicants to the Emergency Service at this Hospital shall have the following qualifications:

a) Satisfactory completion of an ACMGE approved residency;

b) Certified by the American Board in the respective specialty for which privileges are granted; or

c) Formal training in the said specialty and qualification for examination by the American Board. Membership in the service so granted shall be reviewed by the Emergency Service if certification has not been accomplished by the applicant within three (3) years from the date the membership was granted;

d) If the physician does not meet the above qualifications, the Credentials Committee shall review the physician's credentials file and submit their recommendations to the MEC for action. The MEC

shall evaluate the Credentials Committee recommendation and shall make a recommendation for approval or denial.

9.3 EXEMPTIONS

All physicians having privileges at this hospital as of June, 1974, shall be exempt from the requirements of 9.2 regarding board eligibility, certification or service recommendation.

9.4 FUNCTION OF SERVICES

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

a) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it;

(b) Require quality assurance evaluations to be performed for the purpose of improving the quality of care within the service. Each service shall review all major clinical aspects of care performed under its jurisdiction. Patient care evaluation shall be conducted through quality assessment and improvement mechanisms and shall include review, evaluations, recommendations and subsequent action on findings relative to patient care within the service. Each service shall provide effective mechanisms to monitor and evaluate the quality of patient care, including the identification of the important aspects of the care provided by the service, the identification of indicators to be used to monitor the quality of care, and the evaluation of care provided. Each service shall monitor the clinical performance of individuals with delineated clinical privileges. Opportunities to improve care shall be addressed, and important problems in patient care shall be identified and resolved by drawing conclusions, formulating recommendations, initiating actions and communicating these findings to the appropriate members of the service. Practitioners shall be subject to review by each service in which they exercise clinical privileges;

(c) Establish guidelines for the granting, revising or revocation of clinical privileges within the service and submit the recommendations required under Articles III and VI regarding the specific privileges each staff appointee or applicant may exercise and the specified services that each AHP may provide;

(d) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the medical practice. Educational activities shall relate, at least in part, to the type and nature of care offered by the hospital and the findings of quality assessment and improvement activities. The service shall document participation in service offered continuing education of each individual with clinical privileges;

- (e) Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and Hospital policies and procedures; (2) sound principles of clinical practice; and (3) regulations designed to promote patient, visitor, employee and staff safety;
- (f) Coordinate the patient care provided by the service appointees with nursing and other non-physician patient care services and with administrative support services;
- (g) Submit written reports or minutes of service meetings to the MEC, to include: (1) findings of the service review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the service and the Hospital; and (3) such other matters as may be requested from time to time by the MEC or other medical staff committees; and
- (h) Meet as often as necessary for the purposes indicated in (e) above receiving reports on other service and staff functions.

ARTICLE X.
OFFICERS

10.I OFFICERS OF THE STAFF

10.I-1 Identification

The officers of the Staff shall be:

- (a) Chief of Staff
- (b) Vice-Chief of Staff
- (c) Immediate Past Chief of Staff
- (d) Secretary-Treasurer

10.I-2 Qualifications

Officers must be appointees of the Active Staff at the time of nomination and election and must remain appointees in good standing during the term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff and Vice Chief of Staff must be practitioners with demonstrated qualifications for the offices on the basis of experience and ability.

10.I-3 Nominations

- (a) Before the annual Staff meeting of each even-numbered year, the Nominating Committee (refer to Article 11.3.8.2) shall convene and submit to the Chief of Staff one or more qualified nominees for the offices of Chief of Staff-Elect and Secretary-Treasurer, and (2) two members-at-large for the Medical Executive Committee. The Nominating Committee shall report the names of the nominees to the Staff at least sixty (60) days before the annual meeting. Nominations may be accepted from the floor if the nominee consents to the nomination in writing or in person.

10.I-4 Election

Officers shall be elected at the annual meeting of the Staff every other year. Only Staff appointees accorded the prerogative to vote for general staff officers under Article IV shall be eligible to vote. A nominee shall be elected upon receiving a majority of the valid votes cast.

If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. If a tie results from a runoff election, the deciding vote will be cast by the Trustees. The election of officers shall become effective upon approval by the Trustees.

10.I-5 Exceptions

Sections 10.1-3 and 10.1-4 shall not apply to the offices of Chief of Staff and Immediate Past Chief of Staff. The Vice-Chief of Staff shall, upon the completion of his term of office in that position, immediately succeed to the office of Chief of Staff and then to the office of immediate past Chief of Staff.

10.1-6 Term of Elected Office

Each officer shall serve a two-year term, commencing on the first day of the staff year, following his election. Each officer shall serve until the end of his term and until a successor is elected, unless he shall sooner resign or be removed from office.

10.1-7 Vacancies in Elected Office

Vacancies in offices, other than those of immediate past Chief of Staff, Chief of Staff and Vice Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of Vice Chief of Staff or Immediate Past Chief of Staff shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible, following the general mechanism outlined in Sections 10.1-3 and 10.1-4.

10.1-8 Resignation

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

10.1-9 Removal

A two-thirds majority vote by the Medical Staff is required to make a recommendation to the MEC to remove an officer from office. If the MEC concurs with the removal, then recommendation for the removal will be made to the Trustees. If the Trustees do not concur with the Medical Staff recommendation, the decision will be taken back to the Medical Staff for further discussion. The Board of Trustees will make the final decision after clarification by the Medical Staff

10.1-10 Duties of Elected Officers

10.1.10.1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the Chief of Staff are to:

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

Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

Serve as ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;

Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;

Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies approved by the medical staff, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board, and serve as an ex-officio member of the Board, with a vote;

Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,

10.1.10.2 Vice Chief of Staff:

The Vice Chief shall perform the duties of the Chief of Staff in the absence or temporary inability of the Chief of Staff to perform. The Vice Chief shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Board.

10.1.10.3 Immediate Past Chief of Staff: The immediate past Chief of Staff shall be a member of the MEC and shall perform such other advisory duties as are assigned to him by the Chief of Staff, MEC, or the Trustees. He shall serve on the Board of Trustees.

10.1.10.4 Secretary-Treasurer: The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

(a) Maintain a roster of Medical Staff members;

(b) Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

(c)Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff;

(d)Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,

(e)Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority

10.2 OTHER OFFICIALS OF THE STAFF

10.2-I Service Chief

(a) Qualifications: Each chief shall be an appointee of the Active Staff, shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence, through the credentialing process, and shall be willing and able to faithfully discharge the functions of his office.

(b) Selection: The chairperson shall be elected by the Service.

(c) Term of Office: A service chief shall serve a one-year term commencing with his appointment and shall serve until the end of his term and until a successor is elected, unless he shall sooner resign or be removed from office. A service chief shall be eligible to succeed himself. Removal of a service chairperson from office may be done by the Trustees acting upon the recommendation of the MEC, with a two-thirds majority vote of the service members eligible to vote.

(d) Duties: Each chief shall:

(i) Account to the MEC for all administrative, professional, clinical and medical related activities within his service unless provided by the Hospital;

(ii) Develop and implement policies and procedures that guide and support the provision of services and service programs in cooperation with the Chief of Staff and consistent with the provisions of Section 10.4 and Article XI;

(iii) Be a member of the MEC, give guidance on the overall medical policies of the Hospital and Medical Staff and make specific recommendations regarding his own service, and recommendations for a sufficient number of qualified and competent physicians to provide care or service;

(iv) assess and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the service or the organization;

(v) Maintain continuing review of the professional performance of all practitioners with clinical privileges and all affiliates in his service to include orientation and continuing education of all persons in the service and report regularly thereon to the MEC;

(vi) recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the service, and review the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care services, and continued surveillance of the professional performance of all individuals who have delineated clinical privileges;

(vii) Transmit to the appropriate authorities, as required by Articles III, VI and VII, recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners in his service;

(vi) Appoint such committees as are necessary to conduct the functions of the service specified in Section 9.4 and designate a chairperson for each;

(viii) Implement within his service actions delegated by the MEC;

(ix) Participate in every phase of medical administration of his service through the integration of the service into the primary functions of the Hospital; the coordination and integration of interdepartmental and intradepartmental services, through cooperation with the nursing service and other hospital departments;

(x) Assist with the continuous assessment and improvement of the quality of care and services provided as well as the maintenance of quality control programs, as appropriate; and in the preparation of such reports, pertaining to his service as may be required by the MEC, the CEO or the Trustees;

(xi) Appoint an appropriate practitioner of the service to act in the chief's absence;

(xii) Call and conduct all meetings of the service;

(xiii) Participate in the budgetary process affecting the service by making recommendations for space and other resources needed by the service; and

(xiv) Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Chief of Staff, the MEC or the Trustees.

ARTICLE XI
COMMITTEES AND FUNCTIONS

11.I MEDICAL EXECUTIVE COMMITTEE

11.I-I COMPOSITION

The Medical Executive Committee shall be composed of eleven (11) fully licensed physician members of the Medical Staff actively practicing in the Hospital. The membership shall include the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff, the Secretary/Treasurer, the Chief of each Medical Staff Service, two (2) members at large, the Chief Medical Officer and Chief Executive Officer. The Chief Medical Officer (if applicable) and Chief Executive Officer shall be ex-officio members without a vote. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. The Chief of Staff shall serve as the chairperson of the committee.

11.I-2 Duties

The duties of the MEC shall be to:

- (a) Receive and act upon reports and recommendations from the services, standing committees, special committees and officers of the staff concerning the quality assurance activities and the discharge of their delegated medical administrative responsibilities;
- (b) Report results and recommendations concerning staff functions to the Staff and the Trustees;
- (c) Coordinate the activities of and policies adopted by the Staff, services, and standing and special committees;
- (d) Review and recommend to the Trustees all matters relating to medical staff structure, appointments, reappointments, staff category, service assignments, clinical privileges, specified services, and participate in organization performance improvement activities, and corrective action;
- (e) Account to the Trustees and to the Staff for the overall quality and efficiency of medical care rendered to patients in the Hospital;
- (f) Initiate and take appropriate corrective action, when warranted, in accordance with Article VII;
- (g) Make recommendations on medico-administrative and Hospital management matters;

(h) Inform the Staff of the accreditation program and the accreditation status of the Hospital;

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

(j) Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws, and

(k) Act for the medical staff in the intervals between medical staff meetings.

11.1-3 Meetings

The MEC shall meet at least once a month and maintain a permanent record of its proceedings and actions.

11.2 FUNCTIONS

Provision shall be made, either through assignment to the MEC itself, to other appointment staff committees or to a Hospital management committee, for (1) the effective performance of the Staff functions specified and described in Section 11.4, (2) all other Staff functions required by these Bylaws, the Hospital's performance improvement plan and (3) such other Staff functions as the MEC or the Trustees shall reasonably require.

11.3 DESCRIPTION OF OTHER COMMITTEES AND FUNCTIONS

11.3-1 CREDENTIALS COMMITTEE Meet on an as needed basis, but at least quarterly.

(a) The Credentials Committee will consist of physician representatives from each service. Additional Medical Staff members, representing specialty areas, may be appointed to the Credentials Committee as necessary;

(b) The duties involved in coordinating and performing credentials investigations and recommendations are to:

(i) Review and evaluate the qualifications, competence and performance of each applicant for initial appointment, reappointment or modification of appointment and for clinical privileges and make appropriate recommendations;

(ii) Review and evaluate the qualifications, competence, and performance of AHP's in accordance with Article V and make appropriate recommendations;

(iii) Submit a report, in accordance with Articles III and VI, to the MEC on the qualifications of each applicant for Staff appointment or particular clinical privileges. Such report shall include

recommendations with respect to appointment, Staff category, Staff service, clinical privileges or specified services and special conditions attached thereto;

(iv) Investigate, review and report on matters, including the clinical or ethical conduct of any practitioner assigned or referred to it by: (1) the Chief of Staff; (2) the Trustees; or (3) those responsible, respectively, for functions described in Section 11.3-1; and

(v) Document the performance of this function in the Credentials Committee minutes.

11.3-2 EDUCATION/LIBRARY FUNCTION

(a) Each medical staff service may recommend to the Executive Committee educational programs whenever necessary that are designed to keep the Staff informed of significant new developments and new skills in medicine;

(b) Each medical staff service shall evaluate and recommend to the Executive Committee specific educational programs which have been demonstrated through quality assurance programs to be necessary as a result of the hospital's quality improvement processes; and

(c) All professional library needs shall be submitted to the Director of Education.

11.3-3 MULTIDISCIPLINARY Meets twice quarterly.

(a) Membership: Members shall consist of Medical Staff representatives from each service and representatives from Nursing Service, Pharmacy, and Administration.

(b) Functions:

- (i) Pharmacy and Therapeutic
- (ii) Infection Control

(c) Duties:

11.3-3.1 PHARMACY AND THERAPEUTIC:

(i) The Multidisciplinary Committee develops and maintains surveillance over drug utilization policies and practices;

(ii) Assists in the formulation of professional policies regarding the evaluation, appraisal, use, safety procedures and all other matters relating to drugs or IV/parenteral solutions in the Hospital;

- (iii) Makes recommendations concerning drugs to be stocked on the nursing unit and by other services;
- (iv) Develops and reviews periodically a formulary or drug list for use in the Hospital;
- (v) Reviews in detail all reported drug reactions, drug errors, and recommend corrective action;
- (vi) Reviews all data relative to drug effectiveness, side effects and new drugs or uses, and disseminate such information as needed;
- (vii) Establishes standards concerning the use and control of investigational drugs and of research in use of recognized drugs;
- (viii) Performs appropriate drug utilization review and make needed recommendations for staff consideration and implementation;
- (ix) Performs such other duties as assigned by the Chief of Staff; and
- (x) Documentation of the performance of this function shall be reflected in the Multidisciplinary Committee minutes.
- (xi) Responsible for preventing, monitoring and reporting medication errors.
- (xii) All members of the committee shall have voting privileges.

11.3-3.2 INFECTION CONTROL:

- (i) The Multidisciplinary Committee investigates ways to prevent and control Hospital-acquired infections;
- (ii) Maintains surveillance of Hospital infection potentials;
- (iii) Identifies and analyzes the incidence and cause of infections based on a targeted surveillance system;
- (iv) Develops and implements a preventative and corrective program designed to minimize infection hazards;
- (v) Supervises infection control in all phases of the Hospital's activities;

- (vi) Acts upon recommendations related to infection control received from the Chief of Staff, the Trustees, and other Staff and Hospital committees;
- (vii) Maintains a permanent record of all activities relating to infection control and submit periodic reports thereon to the Medical Executive Committee and service committees as necessary; and
- (viii) Documentation of the performance of this function shall be reflected in the Multidisciplinary Committee at least quarterly.
- (ix) All members of the committee shall have voting privileges.

11.3-4 BYLAWS COMMITTEE

(a) The Bylaws Committee shall meet as needed and will include physician representatives from each service.

(b) The duties involved in maintaining appropriate Bylaws, Rules, Regulations, and other organizational documents pertaining to Staff are to:

- (i) Conduct a review as needed but at least annually of the Staff Bylaws and the Rules, Regulations, procedures and forms promulgated in connection therewith;
- (ii) Submit recommendations to the MEC for changes in these documents. The MEC will then submit recommendations to the Medical Staff. Ultimate approval by the Trustees is required for all changes; and
- (iii) Act upon all matters specified in subparagraph (b) as may be referred by the Trustees, the Chief of Staff, the CEO and other committees of the Staff.

11.3-5 CLINICAL ETHICS COMMITTEE

The Clinical Ethics Committee shall be comprised of: a chairperson who is a member of the Medical Staff or Professional Clinical Staff, at least two (2) physician members who shall represent the physicians involved in direct patient care, and should also include representatives of administration, nursing, education, clergy, social work, and a lay representative. Representation need not be limited to the groups specifically named. These individuals shall be appointed by the Administrator upon recommendation of the chairperson of the committee following consent of the committee.

The chairperson may ask other individuals with expertise related to a particular issue to participate in the Committee's deliberations without becoming members of the committee. Legal representation shall be consulted when appropriate.

The purpose of the committee shall be to provide educational and consultative services for ethical issues related to patient care.

All members of the committee shall have voting privileges

11.3-6 MEDICAL RECORDS COMMITTEE

11.3-6.1 Composition

The Medical Record Committee shall be composed of seven voting members including a physician chairperson, who shall be an active member in good standing. In addition, the voting members shall include the Director of Health Information Management, the Director of Performance Improvement, the Director of Education, the Director of Risk and a Nurse Manager.

11.3-6.2 Duties and Authority

The Medical Record Committee shall perform the key function of assisting the medical staff in maintaining the patient care record compliance with medical staff rules and regulations, JCAHO standards, and applicable state and federal laws. The Medical Record Committee will perform the following specific duties:

- (a) Establish standards for format and content of the medical record;
- (b) Monitor the quality of the medical record;
- (c) Provide advice and support to the Medical Record Department in determining systems and procedures which will best enable it to meet the need of the organization;
- (d) Consider revisions and innovations of the medical record processes and procedures as appropriate;
- (e) Review results of multidisciplinary chart audit quarterly to assure quality, clinical pertinence, and timely chart completion are present;
- (f) Create and maintain a list of all abbreviations currently used and approved within the organization.
- (g) All members of the committee shall have voting privileges.

11.3-6.3 Meetings

The Medical Record Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee. Communication of the results and recommendations by the members of the Medical Executive Committee to appropriate medical department meetings will occur quarterly. A report of the Medical Record Committee to the Board of Trustees will occur annually.

11.3-7 PEER REVIEW COMMITTEE

11.3-7.1 Composition

The Peer Review Committee shall be composed of nine (9) voting members who shall be active staff members in good standing. The voting membership shall include three (3) active staff representatives of each of the Medical Staff Departments. In addition to the CEO, the ex-officio members without vote shall also include the Director of Risk and Medical Staff Service. The Peer Review Committee shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the Chief of Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee. Ad hoc members of the committee shall not have voting rights on the committee.

11.3-7.2 Duties and Authority

The Peer Review Committee shall perform the key function of Quality Assessment/Performance Improvement, under the oversight and direction of the Medical Executive Committee. The Quality/Peer Review Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital's performance improvement program through the activities of the Medical Staff Services, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Quality/Peer Review Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual's performance, the committee shall conduct peer review or an ongoing evaluation of the individual's competence and make recommendations accordingly. In addition, the Peer Review Committee shall:

11.3-7.3 Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Services and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

11.3-7.4 Meetings and Reporting

The Peer Review Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.

11.3-8 NOMINATING COMMITTEE

11.3-8.2 Composition

11.3-8.2.1 The Nominating Committee shall be composed of seven voting members (four shall constitute a quorum)

voting members who shall be active staff members in good standing. The voting membership shall include the Chief of Staff who shall chair the meeting, the Immediate Past Chief of Staff, and one active staff member from each Department. The Chief Executive Officer and the Chief Medical Officer, shall serve as ex-officio members without vote. No candidate for election may serve as a member of the Nominating Committee.

11.3-8.3 Duties and Authority

11.3-8.3.1 The Nominating Committee shall perform the key function of Nominating, as described in these Bylaws in Section 10.1.7, under the oversight and direction of the Medical Executive Committee. The Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

11.3-8.4 Meetings and Reporting

11.3-8.4.1 The Nominating Committee shall meet at least every two years during even-numbered years, and shall report their recommendations and activities to the Medical Executive Committee.

11.4 SPECIAL COMMITTEES

11.4-1 Composition and Appointment

If a Special Staff Committee is established by the MEC to perform one or more of the Staff functions required by these Bylaws, it shall be composed of appointees of the Staff and may include, where appropriate, representation from Hospital administration, or any of the services or Hospital departments as is appropriate to the function(s) to be discharged. Unless otherwise specifically provided, the Staff appointees shall be appointed by the Chief of Staff, and the administrative staff appointees shall be appointed by the CEO. Each committee shall select its chairperson where the same are not provided for in these Bylaws.

11.4-2 Term and Prior Removal

Unless otherwise specifically provided, a special committee appointee shall continue as such until the end of his normal period of Staff appointment and until his or her successor is elected or appointed. A Staff special committee appointee, other than one serving ex officio, may be removed by a majority vote of the MEC. An Administrative Staff Committee appointee may be removed by action of the CEO.

11.4-3 Vacancies

Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.

11.4-4 Meetings

A special committee established to perform one or more of the Staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties.

11.4-5 Reporting

11.4-5.1 Special committees shall report their activity to the Service they are assigned.

ARTICLE XII.
MEETINGS

12.1 REGULAR MEETINGS OF THE MEDICAL STAFF

12.2-1 Meeting Time

The staff may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws, but shall be at least quarterly. If the date, hour or place of a regular Staff meeting must be changed for any reason, the notice procedure in Section 12.3 shall be followed.

12.2-2 Order of Business and Agenda

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

(a) Review, correction and acceptance as corrected of the minutes of the last regular and of all special meetings held since the last regular meeting;

(b) Reports from the Chief of Staff, from various committees and services and from the CEO. Reports shall include but not necessarily be restricted to the overall results of patient care evaluation and quality maintenance activities of the Staff, and on the fulfilment of other require Staff functions; and

(c) Other old and new business as appropriate.

12.2-3 Special Meetings of the Medical Staff

Special meetings of the Staff may be called at any time by the Trustees, the Chief of Staff, by action of the MEC or not less than 20% of the appointees of the Active Staff, and shall be held at the time and place designated in the meeting notice. 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 Chief of Staff by mail. Such a vote shall be binding so long as the question is voted on by a majority of the Staff eligible to vote. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.3 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any General Staff meeting, of any special meeting, or of any regular committee or service meeting not held pursuant to resolution, shall be provided to each person entitled to be present thereat not less than five days nor more than 14 days before the date of such

meeting. Notice of service or committee meetings may also be given orally. Each staff member also receives a copy of the Calendar of meetings each month.

12.4 QUORUM

12.4-1 General Staff Meetings

The presence of 30% of the voting appointees of the active staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Bylaws. The presence of 25% of such appointees shall constitute a quorum for the transaction of all other business. A motion will carry with a majority vote (of those present), excluding abstentions. No vote shall be binding if less than a quorum is present at the time of any vote.

12.4-2 Medical Executive Committee

Fifty percent (50%) of the appointees of the Medical Executive Committee shall constitute a quorum for the transaction of all business. If a quorum is not achieved, the meeting will not proceed.

12.4-3 Service and Committee Meetings

Thirty percent (30%) of the voting appointees of a service or committee, but not less than two appointees, shall constitute a quorum at any meeting of such service or committee. If a quorum is not achieved the meeting will proceed as called unless there are less than two appointees present. If there are matters in the minutes which the members not in attendance wish to delay going to the Executive Committee, they shall notify the Administrator in writing, with a copy to the Chief of Staff; otherwise, the minutes shall proceed as if duly acted upon by the whole committee. Matters brought to the attention of the Administrator in this manner will be brought back to the committee at its next meeting.

12.5 MANNER OF ACTION

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

12.6 MINUTES

Minutes of all meetings shall be the responsibility of the Secretary or designate of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the

presiding officer and forwarded to the MEC and made available to the Staff. A permanent file of the minutes of each meeting shall be maintained.

12.7 ATTENDANCE REQUIREMENTS

12.7-1 Regular Attendance

Each appointee of a Staff category (Active and Associate) is required to attend meetings delineated in Article IV

(a) At least 50% of all regularly scheduled staff, service and committee meetings of which he is an appointee. A Staff member shall be required to serve on one committee the appointed service, unless otherwise specified. , , .

(b) No meetings shall be excused.

12.7-2 Special Appearance

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular committee meeting shall be so notified. The chairperson of the meeting shall give the practitioner at least seven (7) days advance written notice of the time and place of the meeting.

ARTICLE XIII.
GENERAL PROVISIONS

13.1 STAFF RULES AND REGULATIONS

Subject to approval by the MEC and Trustees, the Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Staff organizational activities as well as embody the level of practice that is to be required of each Staff appointee or affiliate in the Hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting on notice by those members present and eligible to vote so long as a quorum has been obtained (See Section 12.4 Quorum). Such changes shall become effective when approved by the Trustees.

13.2 SERVICE RULES AND REGULATIONS

Subject to the approval of the MEC and the Trustees, each service shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Staff or other policies of the Hospital.

13.3 FORMS

Application forms, and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Trustees after considering the advice of the MEC.

13.4 CONSTRUCTION OF TERMS AND HEADINGS

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

13.5 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Staff to transmit to the Trustees shall be deemed so transmitted when delivered, unless otherwise specified, to the CEO.

13.6 Application Fee

An application fee, as determined by the Medical Executive Committee upon a recommendation from the Hospital Administrator, will be required for applicants to the Courtesy Staff to offset the costs incurred in processing the

initial application as well as an application for reappointment. These fees will be retained by the Hospital. The Associate and Active staff will not be assessed this fee as they provide services such as emergency department on-call coverage and serve on mandatory committees.

13.7 Dues

Dues may be assessed by the Medical Staff for a specified use, if approved by three-fourths of the Associate and Active Staff members present at a regular or specially called meeting of the Medical Staff, if a quorum of the Associate and Active Staff members are present.

ARTICLE XIV.
ADOPTION AND AMENDMENT OF BYLAWS

MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff Bylaws and Rules and Regulations shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. If the Board and Medical Staff do not agree, a joint committee will be assigned. Notwithstanding anything to the contrary contained herein, the Board shall maintain responsibility and authority over the operation of the Medical Staff and in the event the Medical Staff refuses to amend their Bylaws or Rules and Regulations to comply with local, state or federal laws and regulations or applicable accreditation standards, the Board retains the authority to unilaterally amend the Medical Staff Bylaws and Rules and Regulations to so comply.

EXCULSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

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MEDICAL STAFF BYLAWS/RULES AND REGULATIONS

Upon the request of the Medical Executive Committee, or the Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws/Rules and Regulations. Such action shall be taken at a regular or special meeting of the Medical Staff, provided that written notice of the proposed change was sent to all members of the active staff no less than twenty (20) days prior to the meeting at which the Bylaws/Rules and Regulation changes are to be voted upon. The notices shall include the exact wording of the existing Bylaws/Rules and Regulation language, if any, and the proposed change(s). If a quorum (30% of the full staff) is present as described in Article Thirteen, Section 12. 4-1, for the purpose of enacting a Bylaw or Rule and Regulation change, the change shall require an affirmative vote of greater that fifty percent (50%) present or by ballot.

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text.

SERVICE RULES AND REGULATIONS

a. Service Rules and Regulations: Subject to the approval of the Medical Executive Committee and the Board, each Service shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws and the Rules and Regulations of the Staff or other policies of the Hospital.

TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations.

INTERPRETATION

If any question arises on interpretation of the existing Bylaws an opinion will be sought from the Bylaws Committee.

APPROVED by the Staff on September 11, 2007

BY: _____
Chief of The Staff

BY: _____
Secretary of The Staff

APPROVED by the Board of Trustees on November 13, 2007

BY: _____
Chairman of the Board of Trustees

BY: _____
Secretary of the Board of Trustees