

MEDICAL STAFF BYLAWS
AND
RULES AND REGULATIONS
OF
STRINGFELLOW MEMORIAL HOSPITAL

FOREWORD

Stringfellow Memorial Hospital, located at 301 East 18th Street, Anniston, Alabama, is an acute care, general hospital, owned and operated by Susie P. Parker Stringfellow Memorial Hospital.

ARTICLE I

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Stringfellow Memorial Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, provide oversight of the care, treatment and services provided by practitioners with privileges, and to govern the orderly resolution of these purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff. As adopted or amended, these Bylaws create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital.

ARTICLE II

PURPOSES

The purposes of this organization are:

- A. To develop and adopt Bylaws and Rules and Regulations to establish a framework for self-governance of Medical Staff activities and accountability to the Governing Body for delivery of quality health care services. The organized medical staff enforces and complies with the medical staff bylaws. The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict.
- B. To maintain a qualified Medical Staff whereby all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive quality medical care of the same level as all patients in the Hospital with the same health problems.
- C. To provide a high level of professional performance by all members of the Medical Staff through the appropriate delineation of clinical privileges for each practitioner and through planned systematic ongoing monitoring and evaluation of each Staff member's or Allied Health Professional Affiliate's clinical and ethical performance in the Hospital.
- D. To provide an appropriate atmosphere in which quality educational standards are maintained to afford continuous progress of the Medical Staff in professional knowledge and skill.
- E. To provide a means whereby issues of a medico-administrative nature concerning the Medical Staff, the governing body and the Corporation through the Chief Executive Officer may be discussed and resolved.
- F. To promote, support, and participate in medical programs designed and conducted by the Medical Staff to improve the general health of the community which the Hospital serves.
- G. To promote and support efforts of the Hospital to maintain accreditation of the Hospital by The Joint Commission.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION 1 - NATURE OF MEMBERSHIP

Membership on the Medical Staff of Stringfellow Memorial Hospital shall be extended only to professionally qualified and competent practitioners who strictly and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the member only such admitting and clinical privileges and prerogatives as have been granted by the Governing Body, based upon the recommendations of the Medical Staff and, in accordance with these Bylaws. Practitioners may choose to have membership on the medical staff of Stringfellow Memorial Hospital without privileges. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment and services.

Each physician who is a member of the hospital's medical staff agrees, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the Hospital, any ownership or investment interest in the Hospital that is held by the physician or by an immediate family member (as defined at §411.351 of this chapter) of the physician. Disclosure must be required at the time the referral is made.

SECTION 2 - ELIGIBILITY AND QUALIFICATION FOR MEMBERSHIP

- A. Practitioners shall be eligible for membership on the Medical Staff only if they satisfy all of the following:
- I. Graduate of an approved and accredited medical, osteopathic, dental, or podiatry school;
 2. Registered and possess a current and valid unrestricted license to practice his/her profession in the State of Alabama.
 3. Possession of a current valid Drug Enforcement Agency (DEA) number and Alabama Controlled Substance Certificate (ACSC), if applicable.

4. Live and practice closely enough to the Hospital to provide continuous care of his/her patients (except as otherwise provided in these Bylaws);
 5. Provide adequate documentation of professional education, training, experience, demonstrated competencies as listed by The Joint Commission, judgment, character, integrity, current capability and mental and physical capability; adherence to the ethics of his/her profession; ability to work and cooperate with the Hospital personnel and Staff members; and good reputation to assure the Medical Staff and Governing Body that any patient treated by him/her in the Hospital will be given proper medical care with professional skill.
 6. In order for an applicant to qualify for membership and to remain qualified for membership on the Medical Staff, he/she shall show evidence of professional liability insurance in the amount as determined by the medical staff and hospital board, or limits as mandated by the current licensure law of the State of Alabama, whichever is greater. All applicants for Staff membership will be required to show evidence of such minimum insurance coverage at the time application is made as a pre-requisite to Staff membership. Such insurance shall be maintained during the time that he/she is a member of the Medical Staff.
- B. No practitioner shall be automatically entitled to Medical Staff membership or to exercise admitting and/or clinical privileges in the Hospital merely because he/she is licensed to practice in the state of Alabama, is a member of any professional organization, or has had or presently has, privileges at this or another Hospital.
- C. No aspect of Medical Staff membership or privileges shall be denied or affected because of sex, race, creed, color, religion, national origin or any other criterion lacking professional justification.
- D. Application for membership on the Medical Staff shall constitute the applicant's certification that he/she has in the past, and his/her agreement that he/she will in the future, abide by the Principles of Ethics of his/her professional association. Applicant also agrees to comply with all applicable state and federal laws as well as the Medical Staff Bylaws and Rules and Regulations. The members of the Medical Staff shall maintain the privacy and confidentiality of

patient medical records as required by law and shall not use or disclose such records without proper authority.

- E. House Physicians or Locum Tenens may be used as the demands may warrant. They shall conform to the same standards of performance as the members of the Medical Staff. Their credentials and qualifications must first be reviewed by the Credentials Committee and the Medical Staff Executive Committee and approved by the Governing Body.
- F. Practitioners will notify the Chief Executive Officer immediately of:
 - 1. any suspension or revocation of the individual's license to practice medicine in any jurisdiction;
 - 2. any suspension, revocation, exclusion or involuntary reduction or non-renewal of privileges or rights to participate in Medicare or Medicaid.

Each person possessing privileges at the Hospital shall report to the Chief Executive Officer any of the following events within seven (7) days of the occurrence. Any applicant for privileges at the hospital shall report the following events to the Chief Executive Officer with his/her application or, if occurring subsequent to the submittal of the application and prior to final disposition, to the Chief Executive Officer within seven (7) days of the occurrence. The Chief Executive Officer shall forward such information to the Medical Staff Executive Committee of the Medical Staff in a timely manner. The following events are reportable under this paragraph:

- 1. any suspension, revocation or involuntary reduction or non-renewal of any of the individual's hospital privileges/membership or any resignation under threat of any such action;
- 2. any denial of an individual's application for membership to any hospital staff;
- 3. any disciplinary action initiated against the individual by any medical organization;
- 4. final judgments or settlements involving the individual in any such action above;
- 5. final adverse judgments or settlements involving the individual in any professional liability actions.

The individual involved in such events shall, upon request, appear before the Medical Staff Executive Committee of the Medical Staff and/or the Governing Body, or their respective designees, and give an accurate explanation of the circumstances involving the individual in any of the foregoing events.

- G. An applicant or member upon request by the Medical Staff Executive Committee or the Governing Body shall submit satisfactory evidence of current health status. "Satisfactory evidence" shall consist of a favorable report following examination by one or more members of a panel of physicians to be selected by the Medical Staff Executive Committee in cooperation with the Chief of Staff. All member(s) of the Panel shall examine the applicant or member to determine his/her physical and mental capabilities to perform tasks related to his/her privileges. The examining physician(s) shall submit a written report of his/her findings to the Medical Staff Executive Committee and the applicant or member examined.

The applicant may, at his/her expense, submit a second opinion by a physician(s) of his/her choice to the requesting body. Such opinion must be submitted within ten (10) days of the submission of the first report.

- H. Hospital does not participate in professional graduates education program and has no provisions to supervise residents.

SECTION 3 - ETHICS AND ETHICAL RELATIONSHIPS

The Code of Ethics as adopted or amended by the American Medical Association, American Osteopathic Association, Medical Association of the State of Alabama, Alabama Podiatric Medical Association, Dental Association of Alabama, etc. and as provided in these Bylaws shall govern the professional conduct of the members of the Staff.

Specifically, each applicant and member of the Staff pledges and agrees as follows:

"I authorize Stringfellow Memorial Hospital to request, procure and review any information regarding my medical practice at any institution or from any individual. Moreover, I pledge myself to abide by the Code of Ethics of the American Medical Association, American Osteopathic Association, or my professional organization."

SECTION 4 - STATUS OF MEMBERS

Nothing contained in these Bylaws, nor the fact of Medical Staff membership shall be deemed to create, nor does it create, any type of employment status or relationship between any member of the Medical Staff and the Hospital.

ARTICLE IV
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1 - APPLICATION FOR APPOINTMENT

- A. Applicants for appointment to the Medical Staff shall file with the Chief Executive Officer a written and signed application on a prescribed form furnished by the Hospital, together with his/her professional references.
- I. The application shall require detailed information concerning:
- a. the applicant's professional qualifications;
 - b. the names and addresses of at least three (3) qualified persons with recent, extensive experience in observing and working with the applicant who can provide adequate references pertaining to the applicant's professional competence and ethical character;
 - c. the applicant's membership status and/or admitting and clinical privileges at any other hospital or institution;
 - d. whether his/her medical staff membership has been voluntarily or involuntarily terminated or whether he/she has been the subject to any voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital;
 - e. an original certificate of insurance is obtained from the present malpractice insurance carrier.
 - f. final adverse judgments or settlements involving the applicant in any professional liability actions, including a consent to release of such information from his/her present and past malpractice insurance carrier(s);
 - g. whether he/she have previously successful or currently pending challenges to any licensure or registration (state or district or any jurisdiction, Drug Enforcement Administration) or the voluntary/involuntary relinquishment of such licensure or registration;
 - h. current physical and mental health status including drug and/or alcohol abuse;
 - i. voluntary/involuntary limitation, reduction or loss of clinical privileges or relinquishment of medical license in exchange for discontinuing or in lieu of initiating an investigation of clinical competence.

- j. A Criminal Background Check will be performed on all applicants requesting medical staff privileges at Stringfellow Memorial Hospital (SMH). To promote fairness in the process for applying to the medical staff, SMH will consider an applicant's criminal history on a case-by-case basis. Applicants must disclose all prior arrests and convictions on their applications. Misrepresentations about criminal history, or failure to disclose the same on an application shall void the application process. The Criminal Background Check will help to ensure that the individual requesting medical staff membership approval is the same individual identified in the credentials document.
 - k. Relevant practitioner-specific data are compared to aggregate data, when available.
 - l. Performance Measurement Data including morbidity and mortality data, when available.
 - 2. The applicant shall completely fill in all parts of the application or adequately explain any failure to do so. Falsification of the application in any material respect shall void an application on which an appointment has not yet been made, and subject to disciplinary action, in accordance with the provisions of Article VII of these Bylaws, an individual who has been appointed to the Medical Staff.
- B. The applicant has the burden of producing the information required by these Bylaws and a completed application for proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.
- C. Upon application for appointment to the Medical Staff, each applicant will receive a copy of the Medical Staff Bylaws and Rules and Regulations. The applicant agrees: to be bound by the Medical Staff Bylaws and Rules and Regulations (as amended from time to time); to appear for interviews; to authorize representatives of the Medical Staff and Governing Body to consult with members of other Hospital Medical Staffs with which the applicant has been associated and with others concerning the applicant's professional and ethical qualifications, current competence, and character for Staff membership and other factors, which may be considered in evaluating his/her application, and authorizes such persons to release such information, and to consent to the inspection and copying of any and all records in the possession of any such

hospitals, persons, or other entities which would be material in any evaluation of his/her qualifications and authorize anyone in possession of such records to release them. He/she releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for Staff appointment and privileges, including otherwise privileged or confidential information. He/she agrees to sign the Attestation Statement as required by Medicare.

- D. For applicants for initial appointment to the medical staff or for initial granting of clinical privileges, the hospital verifies the information about the applicant's current licensure, at time of initial granting, renewal and revision of privileges and at the time of license expiration, specific relevant training, experience and current competence provided by the applicant with information from the primary source(s) whenever feasible or from a CVO (Credentials Verification Organization). Licensure and NPDB primary source verification is obtained at initial appointment, reappointment and at any time a new privilege is requested.

The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:

- A current picture hospital ID card
- A valid picture ID issued by a state or federal agency (e.g. drivers license or passport)

SECTION 2 - APPOINTMENT PROCESS

- A. The applicant shall deliver an application to the Chief Executive Officer who shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Chief Executive Officer shall promptly notify the applicant of any problem in collecting such information and it shall be the applicant's responsibility to obtain the information. If the application is not completed within six (6) months, it shall automatically be removed from consideration. When the information is collected and verified, the Chief Executive Officer shall transmit the application and all supporting materials to the chairperson of each department in which the applicant seeks privileges and to the Credentials Committee.

The credentialing process is based on recommendations by the organized medical staff and is approved by the governing body. The Chief Executive Officer shall post the names of applicants in a place in the Hospital convenient to all members of the Medical Staff for viewing.

- B. All reports and recommendations during the review process shall be submitted in writing on a form prescribed by the Medical Staff Executive Committee along with the application and all other documentation considered. Each report shall specify whether membership is recommended and, if so, the category and department and section assignment, the admitting and/or clinical privileges to be granted and any conditions to be attached to the appointment. The report shall state the reasons for each recommendation and support it with reference to the application and documentation considered.
- C. Upon receipt, each department chairperson or his/her designee shall promptly review the application and supporting documentation, may interview the applicant and shall transmit to the Credentials Committee a written report and recommendations according to Section 2 (B) of this Article. A department chairperson may also recommend that the Credentials Committee defer action on the application. The report shall be transmitted to the Credentials Committee within fifteen (15) days of the Department Chief's receipt of the application.
- D. Upon receipt, the Credentials Committee shall promptly review the application, the supporting documentation, the department chairperson's report and recommendations, and such other relevant information as may be available to it and it may interview the applicant. The Credentials Committee shall then transmit to the Medical Staff Executive Committee a written report and recommendations according to Section 2 (B) of this Article. The Committee may also recommend that the Medical Staff Executive Committee defer action on the application. The Credentials Committee shall submit its report to the Medical Staff Executive Committee not more than sixty (60) days after the receipt of the Department report.
- E. At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Staff Executive Committee shall consider the report and such other relevant information available to it and shall make its recommendations to the Governing

Body according to Section 2 (B) of this Article. The Committee may defer action on the application for further consideration of the application until the next regularly scheduled Medical Staff Executive Committee meeting at which time the Executive Committee must make a recommendation to the Governing Body to accept or reject the applicant.

- F. The Governing Body, pursuant to its bylaws, may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the governing body or the governing body, at its next regular meeting following receipt of the Medical Staff Executive Committee recommendation, shall consider the final report and recommendations of the Medical Staff Executive Committee, and accept, reject or modify the report and recommendations. The Governing Body may refer the report and recommendations back to the Medical Staff Executive Committee stating the reasons, in writing, for such referral and setting a time limit within which an additional report shall be made to the Governing Body. At its next regular meeting after its receipt of the additional report, the Governing Body shall make a final decision. All decisions to recommend appointment shall delineate admitting and/or clinical privileges to be granted to the practitioner and assign the practitioner to a category, department or section of the Staff.
- G. The Governing Body or delegated governing body committee has final authority for granting, renewing, or denying privileges. When the Governing Body has taken final action on any application for appointment or clinical privileges to the Medical Staff, it shall, acting through the Chief Executive Officer, notify the Chairperson of the Medical Staff Executive Committee and the applicant of the action taken. If the decision is adverse to the applicant, the Governing Body shall direct the Chief Executive Officer to notify the affected applicant by certified mail, return receipt requested and the applicant shall be entitled to a hearing as prescribed in Article VIII, Section 9 of these Bylaws. The notice to the applicant shall advise the applicant of the reasons for the adverse recommendation, the right to a hearing and shall summarize the applicant's rights during the hearing.
- H. Initial appointment to the Medical Staff shall be on a provisional basis for a period of one (1) year during which the member's professional and clinical performance and activities shall be observed and evaluated by the chairperson of the department to which the member has been assigned or his/her designee. Associate status may be

extended for up to one (1) additional year.

- I. A separate record is maintained for each individual requesting membership or clinical privileges.
- J. Completion of an orientation program provided by the Medical Staff Services Department including introductions to all appropriate Hospital supervisory personnel.

SECTION 3 - PROCTORING - Focused Professional Practice Evaluation (FPPE)

All initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Staff Executive Committee, or the department as designee of the Medical Staff Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the Focused Professional Practice Evaluation (FPPE) period specified in the department's policies and procedures, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or his/her designee. The member shall remain subject to such proctoring until the Medical Staff Executive Committee has been furnished with:

A report signed by the chief of the department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

SECTION 4 - TERMS OF APPOINTMENT

- A. Appointments and reappointments shall be made by the Governing Body, based on Medical Staff Committee recommendations, in accordance with the Bylaws, Rules and Regulations and policies of the Medical Staff.
- B. Appointment to the Medical Staff shall confer on the appointee only such admitting and/or clinical privileges as have been granted by the Governing Body. An applicant for Staff membership must be able to

render continuous and appropriate care and supervision of his/her patients, abide by the Bylaws and Rules and Regulations of the Medical Staff, agree to accept committee assignments and provide emergency care as required under Article VI of these Bylaws. The term of the appointment is not to exceed a two (2) year period.

SECTION 5 - ACCEPTANCE TO STAFF MEMBERSHIP

No applicant shall be deemed to have been accepted for Medical Staff membership except upon application made and fully acted upon according to these Bylaws. Temporary privileges granted pursuant to these Bylaws shall not be deemed to confer upon any applicant any form of Staff membership or any rights and privileges of membership associated with the Medical Staff of the Hospital.

SECTION 6 - REAPPOINTMENT PROCESS

- A. No member shall be automatically entitled to or have a vested right of renewal of membership and privileges.
- B. Each member of the Medical Staff of all categories shall be subject to reappointment one (1) year from the date of initial appointment (except in case of any extension of associate status), and, thereafter, every two (2) years.
- C. By May 1st the Chief Executive Officer shall transmit to the Chief of each service the application for reappointment of all members of that service, together with the clinical privileges each then holds, accompanied by the applications of those persons who have applied for a change in clinical privileges or for a change in medical staff category.
- D. Except as otherwise provided in these Bylaws, no member of the Medical Staff shall be reappointed until his/her current competencies as listed by The Joint Commission, ability to perform the privileges requested, and qualifications have been demonstrated and reviewed. Review shall include:
 - 1. clinical privileges requested, with any basis for change;
 - 2. data issuing from the Medical Staff monitoring and evaluation process and citations, if any, by Medical Staff review committees, including quality of care committees; and the National Practitioner Data Bank

- report;
3. professional performance, current competence and ability, judgment, clinical and/or technical skills, and mental and physical health status;
 4. professional ethics and conduct;
 5. attendance at required Staff affairs and willingness to serve on Staff committees when requested;
 6. continuing medical education since the previous appointment;
 7. conscientiousness in maintaining timely, accurate and legible medical records;
 8. compliance with the Medical Staff Bylaws and Rules and Regulations;
 9. cooperation with Hospital personnel and relations with other Staff members where such cooperation affects patient care; and
 10. appropriate utilization of Hospital facilities.
 11. whether he/she have previously successful or currently pending challenges to any licensure or registration (state or district, or any jurisdiction, Drug Enforcement Administration) or the voluntary/involuntary relinquishment of such licensure or registration;
 12. whether the practitioner has been refused membership on a hospital Medical Staff or request for specific clinical privileges has been denied or granted with stated limitations.
 13. whether his/her medical staff membership has been voluntarily or involuntarily terminated or whether he/she has been the subject to any voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital;
 14. Involvement in a professional liability action, as defined in the medical staff bylaws, including final judgments and settlements involving a practitioner.
 15. Relevant practitioner-specific data are compared to aggregate data if such data are available for that practitioner.
 16. Morbidity and mortality data if such data are available for that practitioner.
 17. Peer recommendations

E. All reports and recommendations during the reappointment process shall be submitted in writing on a form prescribed by the Medical Staff Executive Committee. Each recommendation shall state the Staff

category to be assigned and delineate clinical privileges to be granted. If the recommendation is to (i) deny reappointment; (ii) reduce or increase clinical privileges; (iii) deny a requested increase in privileges or change of staff category, the reason(s) must be stated and supported with reference to documentation considered.

- F. The Chief Executive Officer shall provide each Staff member with a Reappointment application form. The Staff member will be notified at that time that failure to file his/her application for reappointment or failure to provide information necessary to complete the review process will result in voluntary resignation from the Medical Staff at the expiration of the member's current term. Each Staff member who desires reappointment shall, at least ninety (90) days before expiration of his/her appointment, send a Reappointment application to the Chief Executive Officer. Failure, without good cause, to file the application for reappointment shall be considered a voluntary resignation of membership at the expiration of the member's current term. The Chief Executive Officer shall, in timely fashion, collect and verify the information on the application form and collect any other relevant materials or information, including information regarding the member's professional activities, performance and conduct in the Hospital. When the information has been collected and verified, the Chief Executive Officer shall transmit the application and supporting materials to the chairperson of each department in which the Staff member requests clinical privileges.
- G. Upon receiving a member's application for reappointment, each department chief shall review and evaluate the member's Staff membership activities and clinical privileges for reappointment and data provided by the Medical Staff monitoring and evaluation process. The chief shall provide information concerning the member's professional performance, judgment, technical skill, ability to work with and cooperate with Hospital staff and personnel, current competencies as listed by The Joint Commission and ability, and his/her opinion of the Staff member's physical and mental health status as it relates to ability to practice and exercise Hospital and clinical privileges in compliance with these Bylaws. The chairperson shall submit a report to the Credentials Committee.
- H. The Credentials Committee shall submit a written report and recommendation in writing to the Medical Staff Executive Committee according to Section 5(E) of this Article.

- I. The Medical Staff Executive Committee shall submit a report and recommendation to the Governing Body according to Section 5 (E) of this Article.
- J. If the Medical Staff Executive Committee's report to the Governing Body is adverse to the member, he/she shall have the right of hearing and appeal as set forth in these Bylaws. Unless the action taken is a summary suspension, the member's then current status on the Medical Staff with all rights and privileges shall remain in effect pending the outcome of any hearing and appeal, and final action by the Governing Body. However this may not exceed the two year reappointment period. If a staff category change is not approved, this is not considered an adverse event by the NPDB since it does not affect privileges and therefore is not considered 'adverse' and would not mandate that the practitioner be afforded fair hearing and appeal rights.
- K. If the review is not completed due to member's failure to provide requested information, the failure to provide such information shall be deemed a voluntary withdrawal of the application for reappointment and an immediate voluntary resignation from the Medical Staff.

SECTION 7 - LEAVE OF ABSENCE

- A. A Staff member may be granted a leave of absence for academic reasons, health reasons, personal reasons, or military obligations. The member must apply in writing to the Medical Staff Executive Committee, through the appropriate department chairperson. A leave of absence shall not exceed one (1) year. At the end of a leave of absence, the Staff member shall return to the same department or section, in the same Staff category and with the same admitting and clinical privileges.

However, upon granting such leave, the Medical Staff Executive Committee, or the Governing Body, may reserve the right to review the member's admitting and clinical privileges and physical and health status before reinstatement and also may reserve the right to modify the membership and privileges as appropriate. Any modification that is adverse to the member shall be subject to the right of hearing and appeal, pursuant to the provisions of these Bylaws.

- B. Any request by the member after a leave of absence for a change in department, Staff category and/or clinical privileges shall be processed in a reasonable time.
- C. A leave of absence shall not relieve a member of the obligation to comply with Article IV, Section 5 concerning reappointment in a timely manner.

SECTION 8 - RESIGNATION FROM MEDICAL STAFF

- A. Any member who desires to resign from the Medical Staff must submit a letter of resignation through his/her assigned department chairperson, to the Medical Staff Executive Committee of the Medical Staff and the Chief Executive Officer. The Medical Staff Executive Committee shall forward its recommendation to the Governing Body, which shall take the final action.
- B. A request for resignation shall not be considered until all obligations to the Hospital have been satisfactorily met by the member, including completion of all medical records, or arrangements satisfactory to the Hospital.
- C. Any member not complying with this Section shall be considered as having resigned from the Staff not in good standing.
- D. Any resignation or voluntary relinquishment while under investigation will require reporting to the National Practitioners Data Bank.

ARTICLE V

CLINICAL PRIVILEGES

SECTION 1 - CLINICAL PRIVILEGES RESTRICTED

Medical Staff members or others practicing at Stringfellow Memorial Hospital shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as otherwise provided in these Bylaws. The privileges shall only be within the scope of the licensure, certification or other legal limitations authorizing the practitioner's practice. The management of each patient's care is the responsibility of a qualified licensed independent practitioner with appropriate clinical privileges. Licensed independent practitioners with appropriate privileges manage and coordinate the patient's care, treatment and services.

The hospital based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:

- Current licensure and/or certification, as appropriate, verified with the primary source.
- The applicant's specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privileges
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner's performance within the hospital.

An applicant submits a statement that no health problems exist that would affect his/her ability to perform the privileges requested.

SECTION 2 - APPLICATION FOR PRIVILEGES

Applications for Staff appointment or reappointment must contain a request for the specific clinical privileges desired by the applicant supported by documentation of the applicant's relevant recent training and/or experience. Requests for privileges will be processed in the same manner as applications for appointment or reappointment to the Medical Staff.

The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. If privileging criteria is used that are unrelated to quality of care, treatment and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment and services is evaluated. The process to disseminate all granting, modification or restriction decisions is approved by the organized medical staff.

SECTION 3 - DELINEATION OF PRIVILEGES

- A. Initial requests for clinical privileges shall be evaluated based upon the applicant's documented education, training, experience, references, specialty board qualifications (those qualifications which are recognized by the American Board of Medical Specialties, the American Osteopathic Board, or by the American Board of Oral & Maxillofacial Surgery), demonstrated current competence, ability, judgment, and licensure; the criteria are developed by each department of the Medical Staff. All of the criteria used are consistently evaluated for all practitioners holding that privilege.
- B. Upon reappointment, requests for clinical privileges shall be based on the member's training, experience, specialty board qualifications (those qualifications which are recognized by the American Board of Medical Specialties or by the American Osteopathic Board), competencies as listed by The Joint Commission, judgment, and current capability, which shall be evaluated by reviewing the practitioner's credentials, results of treatment, documented participation in continuing professional education, the peer review records, which include conclusions drawn from organization performance improvement activities when available, and reports of the Medical Staff, and observing the care rendered.

When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges.

- C. The practitioner applying for appointment or reappointment shall have the burden of establishing his/her qualifications and competence to exercise the clinical privileges requested.
- D. A member of the Medical Staff may apply for privileges to work in the Emergency Care Center (ECC) as long as he/she is willing to abide by the conditions established by the Credentials Committee and is

competent to perform these privileges. The conditions are as follows: 1) Member must have a current ATLS, ACLS and Medical Director Course Certification; 2) Physician would not be allowed to work in the ECC on days he/she is scheduled to be on the ER OnCall Schedule; 3) If a patient of the physician is seen in the ECC and needs to be admitted; the physician would have to contact the ER OnCall physician for admission.

SECTION 4 - DENTIST PRIVILEGES

- A. Privileges granted to dentists shall be based on their training, experience, demonstrated competence, judgment, current capability, and licensure. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical procedures and shall be under the overall supervision of the Chief of the Department of Surgery.
- B. Dental members of the Medical Staff may treat dental patients at the Hospital under the jurisdiction of the Department of Surgery and shall designate a physician staff member as having primary medical responsibility for the patient in the patient's medical record upon admission. All dental patients must have the same basic medical appraisal as patients admitted to other services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. All dental patients must have a history and physical appraisal performed by a physician member. The dentist is responsible for that part of the history and physical examination related to dentistry.
- C. Dentists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.
- D. Oral Surgeons who admit patients without significant medical problems may perform an admission history and physical examination and assess the medical risks of the procedure on the patient if they have privileges to do so. Criteria to be used in granting such privileges shall include, but shall not necessarily be limited to, the following: successful completion of a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education; and, as determined by the Medical Staff, evidence of current competence to conduct such a history and physical and assessment. Patients with

significant medical problems admitted to the Hospital by qualified Oral Surgeons shall receive the same basic medical appraisal as patients admitted to other services.

SECTION 5 - PODIATRIST PRIVILEGES

- A. Privileges granted to podiatrists shall be based on their training, experience, demonstrated competence, judgment, current capability and licensure. The scope and extent of their medical and surgical privileges shall be specifically delineated and granted in the same manner as all other medical and surgical procedures and shall be exercised under the overall supervision of the Chairperson of the Department of Surgery.
- B. A podiatrist member may admit patients to the Hospital under the jurisdiction of the Department of Surgery and shall designate a physician member with appropriate privileges to have primary medical responsibility for the patient in the medical record upon admission. All podiatry patients must have a history and physical appraisal performed by the physician member. The update to the history and physical on the day of the procedure will be performed by the physician member. The physician shall be responsible for the care of any medical problem that may be present on admission or arise during the patient's hospitalization and shall signify willingness to do so in the medical record. The physician and the podiatrist shall assess, with consultation if necessary, the overall risk and effect of surgery on the patient's health.
- C. Podiatrists may write orders and prescribe medications within the limits of their licensure and privileges granted pursuant to these Bylaws.
- D. Podiatrists shall be active members who may vote and hold office.

SECTION 6 - ALLIED HEALTH PROFESSIONAL AFFILIATES

Allied Health Professional Affiliates who are not licensed physicians or dentists, but who may, in the opinion of the Credentials Committee, because of their scientific skills, contribute to patient care, education or research, may be granted certain clinical privileges in the Hospital as specified in the paragraphs below. The allied health professionals may attend Medical Staff committees and meetings and give advice to members

of the Medical Staff. They may not vote or hold office. They may not admit patients or write orders except when otherwise specified in this section and the rules and regulations of these bylaws. They are only allowed to practice within the parameters of the privileges they have been granted. Their opinion which shall be written in the form of a consultation shall become a part of the Hospital records.

The Credentials Committee shall be responsible for the delineation of privileges of allied health professionals in the same manner as specified in Article IV and within the scope as set forth by Alabama law. In addition, the Credentials Committee of the Medical Staff in order to properly discharge its functions may, if it deems necessary, require further information from the applicant and/or applicant's privileges employer. The credentialing process for AHPs should be the same as for the medical staff, adapted for the training of the AHP. This may include additional letters of recommendations, information from previous employers, information from other hospitals where the applicant has worked, or personal interview with the applicant or any other information that the committee deems necessary. It is noted that one reference for the allied health professional must be from a peer (someone with the same professional degree). The applicant shall cooperate fully with the Credentials Committee in order that the Committee may fully and adequately determine the moral, ethical and professional qualifications of the applicant. Below is a listing of such Allied Health Professional Affiliates, but not limited to:

A. Requirements for Granting of Privileges for Clinical Psychologist:

Each applicant shall follow the same general procedure as delineated in Article IV of these bylaws for the granting of clinical privileges with the following additions:

1. Every applicant shall have a Doctorate in Psychology, or equivalent degree, shall be licensed as a Psychologist by the Alabama Board of Examiners in Psychology, and shall have a specialty in the area of Clinical Psychology with a minimum requirement of an approved clinical internship.
2. Every applicant shall provide an original certificate of insurance indicating medical liability is in force and in the amount required.
3. The delineation of clinical privileges for Clinical Psychologist shall be within the scope as set forth by Alabama Law.

Should the applicant be granted privileges by the Governing Body as a Clinical Psychologist, the applicant shall be placed under the supervision of the Department of Medicine.

B. Requirements for Granting Privileges for use of physician's assistant (PA) by a member of the Medical Staff:

Every medical staff member who employs a physician's assistant and wishes to use the physician's assistant in the hospital shall cause the physician's assistant to follow the same general procedure as delineated in Article IV of these bylaws for the granting of clinical privileges with the following additions:

1. Every Medical Staff applicant shall produce adequate proof of employment of the physician's assistant.
2. The member of the Medical Staff making application for the privileges of employing a physician's assistant shall provide certain information to the Credentials Committee as follows:
 - A statement from the Alabama State Board of Medical Examiners to the effect that the proposed physician's assistant has met all the requirements of state law, has been certified by the Board of Medical Examiners and that the proposed physician's employer has been granted approval to employ said assistant.
 - Evidence that medical liability insurance is in force and in the amount required for the physician's assistant.
3. The activities of the physician's assistant shall be within the scope as put forth by Alabama Law.

Should the applicant be granted privileges by the Governing Body as a physician's assistant, the physician's assistant shall be placed under the direct supervision of the Medical Staff member who made application for the employment of said assistant.

C. Requirements for Granting of Privileges for Certified Nurse Practitioner:

Each applicant shall follow the same general procedure as delineated in Article IV of these bylaws for the granting of clinical privileges with the following additions:

1. Every applicant shall have a current active license as a registered nurse in the State of Alabama.
2. Every applicant shall be certified by the Alabama State Nurses Association.
3. Every applicant shall have documentation of completion of a nurse practitioner program conducted by a state approved school of nursing that offers at least a baccalaureate degree in nursing or such a school conjointly with an A.M.A. L.C.M.E. accredited school of medicine. The program shall be:
 - At least one academic year in length and provide instruction in the biological, behavioral and medical sciences relevant to the area of advanced practice and sufficient supervised clinical experience under a preceptor board certified in his/her appropriate area for beginning practice as an advanced registered nurse practitioner.
 - Master's preparation in nursing with a specified Nurse Practitioner core in the clinical specialty area; or
 - A Baccalaureate program with a specific curriculum for Nurse Practitioners include medical and nursing modalities with the description above.
4. Every applicant shall have two letters of reference documenting current clinical competencies from professional members of the health team who have had the opportunity to observe and evaluate clinical competencies of the Nurse Practitioner. One reference must be from a clinical peer.
5. Every applicant shall provide an original certificate of insurance indicating medical liability is in force and in the amount required.
6. The delineation of clinical privileges for Certified Nurse Practitioner shall be within the scope as set forth by Alabama Law.

Should the applicant be granted privileges by the Governing Body for clinical privileges as a Nurse Practitioner, the applicant shall be placed under the appropriate Medical Staff Department based on the applicant's clinical specialty.

D. Requirements for Granting of Privileges for Certified Registered Nurse Anesthetist (CRNA):

Each applicant shall follow the same general procedure as delineated in Article IV of these bylaws for the granting of clinical privileges with the following additions:

1. Every applicant shall be a graduate of a regular approved school of nursing.
2. Every applicant shall be a registered nurse in the State of Alabama or shall be registered in another state and in the process of becoming registered in the State of Alabama.
3. Every applicant shall be a graduate of an approved school of nurse anesthesia.
4. Every applicant shall be or in the process of becoming certified by the American Association of Nurse Anesthetists.
5. Every applicant shall provide an original certificate of insurance indicating medical liability is in force and in the amount required.
6. The delineation of clinical privileges for Certified Registered Nurse Anesthetist shall be within the scope as set forth by Alabama Law.

Should the applicant be granted privileges by the Governing Body as a Certified Registered Nurse Anesthetist, the applicant shall be placed under the direct supervision of an Active or Associate Anesthesiology Medical Staff member of the Department of Surgery.

SECTION 7 - TEMPORARY PRIVILEGES

- A. Upon receipt of an application for Medical Staff membership, or under such other circumstances that the Medical Staff Executive Committee may deem appropriate, the Chief Executive Officer, with approval of the appropriate Department Chief and the Chief of Staff (or in his/her absence, the Chairperson of the Credentials Committee) shall have

the authority to grant temporary clinical privileges, but not membership status, to any appropriately licensed Practitioner who is not a member of the Medical Staff. There are two circumstances for which the granting of temporary privileges shall be granted: 1) To fulfill an important patient care, treatment and service need; or 2) When an new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Body. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence. Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following: Current licensure; Relevant training or experience; Current competence; Ability to perform the privileges requested; Other criteria required by the organized medical staff bylaws; A query and evaluation of the NPDB information; A complete application; No current or previously successful challenge to licensure or registration; No subjection to involuntary termination of medical staff membership at another organization; No subjection to involuntary limitation, reduction, denial or loss of clinical privileges. In the exercise of such privileges, the applicant shall act under the direct supervision of the Chairperson of the Department to which he/she is assigned. An applicant to the Medical Staff is not automatically entitled to temporary privileges nor does the granting of temporary privileges imply any guarantee that membership or permanent privileges will be granted.

- B. Temporary privileges shall not extend beyond one hundred twenty (120) days from the time first granted.
- C. The Chief Executive Officer may at any time, upon the recommendation of the appropriate Department Chief or the Chief of Staff, terminate the practitioner's temporary clinical privileges effective as of the discharge from the hospital of the patient(s) then under his/her care. However, where the life or health of such patient(s) could be endangered by continued treatment by the practitioner, the Chief of Staff, the Department Chief or the Chief Executive Officer, may terminate the temporary privileges effectively immediately. The appropriate Department Chief or, in his/her absence/ the Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until they are discharged from the hospital or have chosen another practitioner with appropriate clinical privileges in the Hospital.

- D. Special requirements of supervision and admissions may be imposed on the practitioner to whom temporary privileges are granted. The Chief Executive Officer may immediately terminate the temporary privileges if the practitioner fails to comply with such requirements. The Chief Executive Officer of the Chief of Staff may terminate temporary privileges upon an adverse recommendation by the Medical Staff Executive Committee or the Governing Body as to applicant's application, pending final determination and disposition of the application.
- E. A practitioner whose temporary privileges have been terminated pursuant to this Section shall have no right to the hearing and appeal provided by these Bylaws.

SECTION 8 - EMERGENCY PRIVILEGES

In an emergency, practitioners registered and legally licensed to practice in Alabama shall, to the degree permitted by their license, and regardless of Staff membership or privileges, be permitted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including calling for assistance or any consultation necessary or desirable. When an emergency no longer exists, such practitioner must request temporary clinical privileges necessary to continue to treat the patient as provided herein or if such privileges are denied or he/she does not request privileges, the patient shall be assigned to an appropriate member of the Active Staff.

SECTION 9 – DISASTER PRIVILEGES

A. To better fulfill its health care mission in time of emergency or disaster, Stringfellow Memorial Hospital's policy is to allow granting of disaster privileges to volunteers eligible to be licensed independent practitioners. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the hospital and its patients, and on the qualifications of its volunteer practitioners. (as per policy MS 08 Disaster Privileging Policy)

The Chief of Staff (or his designee) may, at his or her discretion, grant disaster privileges. When disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent

practitioners in the hospital must at a minimum present a valid government-issued photo identification issued by a state or federal agency (for example, driver's license or passport) and at least one of the following:

- a) A current picture hospital ID card that clearly identifies professional designation;
- b) A current license to practice
- c) Primary source verification of the license;
- d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other organized state or federal organizations or groups;
- e) Identification indicating that the individual has been granted authority to render patient care, treatment and services in a disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- f) 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.

All documents shall be photocopied and the copies shall be placed in the volunteers file. The name of any hospital or medical staff member who has vouched for the volunteer also shall go in the file. The Volunteer shall be granted core privileges on an emergency basis for his/her specialties. The Chief of Staff (or his designee) shall assign tasks consistent with the hospital's immediate needs. The MS 08 Disaster Privileging policy will be followed during and after the disaster.

SECTION 10 - LOCUM TENENS

- A. Any member of the Active Staff in good standing may have an appointment granted to a Locum Tenens when the member is temporarily absent from his/her practice because of vacation, illness, military service, or attendance at a medical post-graduate educational course. The privileges of the Locum Tenens shall depend on his/her training and experience as presented in the application of appointment endorsed by the member and approved by the appropriate Department Chief, the Chief of Staff and the Chief Executive Officer (or his designee). The privileges of the Locum Tenens shall not exceed those of the member who is temporarily replaced. Locum Tenens practitioners can be privileged either through the traditional medical staff privileging mechanism or through

the temporary privileges pathways and must meet the appropriate requirements of these pathways.

- B. The privileges of a Locum Tenens may, at any time upon the recommendation of the appropriate Department Chief or the Chief of Staff, be terminated immediately by the Chief Executive Officer where there is reason to believe that it would be in the best interest of the Hospital or patient care. The Department Chief or the Chief of Staff shall assign a member of the Active Staff to assume responsibility for the care of such patient and the desire of the patient shall control if possible. If privileges are terminated under this provision, the Locum Tenens shall have no right to a hearing and appeal under these Bylaws. Locum Tenens physicians are to be afforded fair hearing and appeal rights as those noted for those with temporary privileges.

ARTICLE VI

CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories: Active, Courtesy, Consultant, Honorary, Associate and Community Care Staff.

SECTION 2 - ACTIVE STAFF

- A. The Active Staff shall consist of practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the hospital, who live and practice within a reasonable distance from the Hospital in order to provide continuous care and supervision of their patients and close enough to respond in a timely manner to emergency patient contacts, and who assume active participation in the prescribed duties and functions of the Medical Staff, and otherwise meet the qualifications as prescribed in these Bylaws, including the application.
- B. Members of the Active Staff shall be eligible to vote, hold office, and serve on Medical Staff Committees. They shall be responsible to perform Staff assignments and attend Medical Staff and Department meetings.
- C. Members of the Active Staff shall retain full responsibility within their area of professional competence for the continuous care and supervision of their patients in the Hospital, or arrange a suitable alternative (as approved by the appropriate Department Chief) for such care and supervision. Active Staff members shall actively participate in quality assurance activities required of the Staff, and they shall faithfully discharge all Staff functions as may be required from time to time.
- D. Active Staff members shall be given primary consideration for available beds and ancillary services for their patients where there is a choice in which no harm can result to a patient.
- E. Active Staff members shall serve on the Emergency Department On-Call Service and may act as consultants if granted appropriate privileges. Any physician who has 30 years of service on the Medical

Staff or who is 60 years of age may be exempt from Emergency Department On-Call Service if he/she makes his/her request known in writing.

SECTION 3 - COURTESY STAFF

- A. The Courtesy Staff shall consist of members who only occasionally admit patients to this Hospital, are located closely enough to the Hospital to provide continuous care and supervision to their patients and close enough to respond in a timely manner to emergency patient contacts, and are on the Active Staff in good standing at another Hospital which is located closely enough to allow the member to service patients at both Hospitals.
- B. Members of the Courtesy Staff, with the exception of members of Emergency Medicine, Pathology and Radiology Departments shall be privileged to have no more than twelve (12) patient contacts per year. Contacts shall mean either Admissions or Same Day Surgery procedures.
- C. Members of the Courtesy Staff shall not be eligible to vote or hold office, shall not take Emergency Department On-Call, but may be assigned to serve as members of the Medical Staff Committees as determined by the Chief of Staff.
- D. Members of the Courtesy Staff who signify a willingness to advance to Active Staff membership shall be considered as provided in Articles IV and V of these Bylaws.

SECTION 4 - CONSULTING STAFF

- A. The Consulting Staff shall consist of members representing selected specialties or medical abilities who are willing to accept such appointment. These practitioners are not required to live or practice close to the Hospital.
- B. Members of the Consulting Staff may not admit patients and shall not be eligible to vote, hold office or take Emergency Department On-Call. They may serve as non-voting members of Hospital Committees.
- C. Members of Consulting Staff who signify a willingness to advance to Active Staff membership shall be considered as provided in Articles IV and V of these Bylaws.

SECTION 5 - HONORARY STAFF

- A. The Honorary Staff shall consist of retired members who have been recognized for their noteworthy contributions to the Hospital, outstanding reputation or achievement or long-standing service to the Hospital.
- B. Members of the Honorary Staff shall not be eligible to vote or hold office.

SECTION 6 - ASSOCIATE STATUS

- A. All initial appointments to or reassignments to any category of the Medical Staff shall be provisional for at least 12 months, and may be extended for up to one additional year. During the provisional period, the member's professional and clinical performance and activities shall be observed and evaluated by the Chief (or his/her designee) of the Department to which the member is assigned to determine eligibility for regular status and exercising the admitting and clinical privileges granted to them.
- B. If at the end of the provisional period, the member does not qualify for regular status, the member may be reassigned to the previous category or his/her membership and privileges may be terminated by the Board of Trustees subject to the right of hearing and appeal.
- C. Associate members shall not be eligible to vote or hold office but shall serve on Medical Staff Committees, except Executive, Credentials, and Nominating. They shall attend general Medical Staff meetings as well as Department meetings. They shall serve on the Emergency Department On-Call Service.
- D. There will be two sub-categories of provisional status membership, Associate/Active for those members eventually seeking Active staff membership, and Provisional/Courtesy for those members eventually seeking Courtesy status.

SECTION 7 - HOUSE OR LOCUM TENENS PHYSICIANS

A Practitioner who is appointed by the Hospital as House or Locum Tenens staff shall receive appointment within the designated category. Departmental assignment, privileges, responsibilities and

all other matters relating to each Practitioner appointment shall be governed by the assigned department.

SECTION 8 – COMMUNITY CARE STAFF

- A. The Community Care Staff shall consist of those primary care physicians who wish to be affiliated with the Hospital and refer patients to members of the Active and Courtesy Staff but who do not admit or treat patients in the Hospital.
- B. Members of the Community Care Staff:
May not admit, write orders for inpatient care, (all orders written by a Community Care staff physician must be reviewed with an admitting physician before implementation), perform surgical or invasive procedures or otherwise treat patients in the Hospital, and shall not have delineated clinical privileges.
- C. Shall not be required to meet any activity requirements.

ARTICLE VII

DISCIPLINARY ACTION

SECTION 1 - DISCIPLINARY ACTION

- A. Corrective action against a practitioner with clinical privileges may be requested whenever that practitioner engages in, makes, or exhibits acts, statements, demeanor, or conduct, either within or outside of the Hospital which is, or is reasonably likely to be, detrimental to patient or employee safety or to the delivery of quality patient care within the Hospital. Corrective action also may be requested if the practitioner's acts, demeanor, statements or conduct result, or are reasonably likely to result, in the imposition of sanctions against the practitioner or the Hospital by any governmental authority.
- B. All requests for disciplinary action shall be addressed in writing to the Chairperson of the Medical Staff Executive Committee and shall refer to the specific activity or conduct which constitutes the grounds for the request. If the Medical Staff Executive Committee initiates the request, it shall make an appropriate record of the reasons therefore. The Chairperson of the Medical Staff Executive Committee shall notify the Chief Executive Officer in writing of all requests for disciplinary action, and shall apprise him/her of any action taken. Initiation of an investigation or disciplinary action shall not preclude imposition of a summary suspension under Section 2.
- C. If the Medical Staff Executive Committee concludes an investigation is warranted regarding conduct that could result in a disciplinary action, it shall direct an investigation be undertaken. The Chairperson of the Medical Staff Executive Committee may request the Medical Staff Executive Committee to conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Department Chief or ad hoc committee of the Medical Staff. The affected member shall be notified in writing, by certified mail, that an investigation has been initiated and the general nature of the complaint. If the investigation is delegated to an officer or committee other than the Medical Staff Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Chairperson of the Medical Staff Executive Committee within thirty

(30) days after receipt of the request. The report may include recommendations for appropriate corrective action. Before the report is made, the affected member shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate, which may include an appearance before the investigating body or its designee. The individual or body investigating the matter may also, but is not obligated to, conduct interviews with persons involved. Such appearance or interviews shall not constitute a "hearing" as that term is used in Article XII, nor shall the procedural rules with respect to hearings apply. A record of such appearance and/or interview shall be made by the investigating body and included in its report. Despite the status of any investigation, at all times the Medical Staff Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

- D. The Medical Staff Executive Committee shall consider the report of the investigating body within thirty (30) days after receiving it. If the report recommends suspension, reduction or revocation of membership on the Medical Staff or clinical privileges, and if the member requests it, he/she shall be permitted to appear before the Medical Staff Executive Committee before it acts on such report. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided by these Bylaws with respect to hearings shall apply. A record of such appearance shall be made by the Medical Staff Executive Committee.
- E. The action of the Medical Staff Executive Committee may include, without limitation:
 - 1. Determining no corrective action be taken and, if the Medical Staff Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file.
 - 2. Deferring action for a reasonable time where circumstances warrant.
 - 3. Issuing letters of admonition, censure, reprimand, or warning (although nothing herein shall be deemed to preclude Department Chairs from issuing informal written or oral

warnings outside of the mechanism for disciplinary action in this Article). In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file.

4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or supervision.
 5. Recommending reduction, modification, suspension or revocation of clinical privileges.
 6. Recommending reduction or membership status or limitation of any prerogatives directly related to the member's delivery of patient care.
 7. Recommending suspension, revocation or probation of Medical Staff membership.
 8. Taking other actions deemed appropriate under the circumstances.
- F. If disciplinary action is recommended by the Medical Staff Executive Committee, notice thereof shall be transmitted in writing to the member. If the action is one listed in Article VIII, Section 2, the member shall be entitled to a formal hearing as set forth in Article VIII. All other actions shall entitle the member to an interview with the Medical Staff Executive Committee before it sends its recommendations to the Governing Body.
- G. The member, upon receiving the notice of the recommended disciplinary action, may waive all further proceedings as outlined herein and request a final hearing before the Governing Body. Such a request shall acknowledge that it constitutes a waiver of any further rights to hearing procedures and appeals according to these Bylaws. Such request shall be in writing to the Chief Executive Officer within fourteen (14) days after receipt of such notice.
- H. Upon receipt of the report and recommendations of the Hearing Committee, the Medical Staff Executive Committee shall consider the Hearing Committee's report and its recommendations and shall thereafter forward its recommendation to the Governing Body and provide notice thereof to the member, which, if adverse to the

member, shall be in accordance with Article VIII, Section 3(A).

SECTION 2 - SUMMARY SUSPENSION

- A. The Chief of Staff, any Department Chiefs, the Chief Executive Officer on behalf of the Governing Body, and the Executive Committee of either the Medical Staff or the Governing Body shall each individually have the authority, upon a determination that immediate action is required to protect, or to reduce the substantial and imminent likelihood of significant impairment of the life, health or safety of any patient, employee, or other person, to summarily suspend all or part of a member's admitting and/or clinical privileges and membership. Imposition of summary suspension may be either orally or in writing, and unless otherwise stated, such summary suspension shall become effective immediately upon imposition and remain in effect until further action is taken with respect thereto, in accordance with this Section. Written notice of the summary suspension shall be given promptly to the affected member, the Governing Body, the Medical Staff Executive Committee and the Chief Executive Officer.
- B. Immediately upon the imposition of a summary suspension, the Chief of Staff, in consultation with the appropriate Department Chief, shall have authority to provide for alternative medical coverage for the patients of the suspended member in the hospital at the time of such suspension. The wishes of the patient shall determine, if possible, the selection of such alternative member.
- C. The notice of the summary suspension shall constitute a request for disciplinary action and the procedures in Section I of this Article shall then be followed. The notice to the affected members shall also conform to Article VIII, Section 3(A).
- D. As soon as practical, but not later than seven (7) business days after imposition of the summary suspension, the Chairman of the Medical Staff Executive Committee shall request the Medical Staff Executive Committee to convene to review the summary suspension. The affected member may, upon request, attend the meeting and make a statement concerning the summary suspension, on such terms and conditions as the Medical Staff Executive Committee may impose. This meeting shall constitute only an interview and not a hearing within the meaning of Article VIII. The Medical Staff Executive Committee may continue, or terminate the summary suspension, or modify its terms. If the decision of the Medical Staff Executive

Committee is adverse to the member, reasonable efforts shall be made to proceed promptly with the investigation, hearing and appeal process.

- E. Unless the Medical Staff Executive Committee recommends termination of the summary suspension, the terms of the summary suspension as continued or modified by the Medical Staff Executive Committee shall remain in effect pending the disciplinary process and any hearing and appellate review afforded under Article VIII. If the Medical Staff Executive Committee recommends termination of the summary suspension, the suspension shall be lifted pending final action by the Governing Body. The final result of the disciplinary process shall substitute for the summary suspension.

SECTION 3 - AUTOMATIC SUSPENSION

- A. In the following instances, the member's privileges or membership may be suspended or limited as described:
 - 1. Medical Records: When a member fails to complete medical records within the time prescribed by the Medical Staff Rules, he/she shall be given a warning. If the member fails to complete the medical records within seven (7) days after receiving the warning, the member's privileges to admit patients (except in life-threatening emergency situations) and to schedule elective surgery shall be automatically suspended until such medical records are completed. Failure to complete the records within six (6) months after receiving such a warning shall be deemed an immediate voluntary resignation of the member's Medical Staff membership and privileges. Automatic suspension under this provision three times within a twelve month period shall be deemed an immediate voluntary resignation of the member's Medical Staff membership and privileges.
 - 2. Licensure: Action by the State Board of Medical Examiners and/or Alabama Medical Licensure Commission revoking, suspending, or limiting a member's license shall result automatically in a comparable revocation, suspension or limitation of all or part of the member's admitting and clinical privileges. If the member's admitting and clinical privileges have been revoked or suspended and his/her license is not reinstated in good standing within six (6) months, it shall be deemed an immediate voluntary resignation of the member's

Medical Staff membership and privileges.

3. Controlled Substances: Upon revocation, suspension, or limitation of a member's DEA certificate, the member's right to prescribe medications covered by such certificate shall be automatically revoked, suspended or limited, in a comparable manner, for the duration of such revocation, suspension or limitation.
 4. Malpractice Insurance: If a member fails to maintain the minimum amount as determined by the medical staff and hospital board, his/her membership and admitting and clinical privileges shall be automatically suspended until he/she provides evidence of such minimum insurance coverage. Failure to provide evidence within six (6) months after the suspension shall be deemed an immediate voluntary resignation of Medical Staff membership and privileges.
 5. Conviction of any Felony: If a member is convicted of any felony, the member's admitting and clinical privileges and Medical Staff membership shall be automatically suspended. If the conviction is upheld, the member shall be deemed to have immediately voluntarily resigned from the Medical Staff.
- B. The Chief of Staff, with the cooperation of the Chief Executive Officer, shall enforce all automatic suspensions.
- C. A member whose membership or privileges are automatically suspended, revoked or limited under this Section, or who shall have been deemed to have voluntarily resigned from the Medical Staff, shall have no right to a hearing or appellate review, as otherwise provided for in these Bylaws.

ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 1 - DEFINITIONS AND PREAMBLE

- A. Except as provided in Section 10 of this Article, only members of the Medical Staff shall be entitled to the hearing and appellate review procedure provided in this Article.
- B. A member shall be entitled to only one hearing and one appellate review before receiving a final determination.
- C. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct.
- D. In case of an adverse action or recommendation, the member shall exhaust all hearing and appeal procedures afforded by these Bylaws before resorting to any legal action on either procedural or substantive grounds. Under the Health Care Quality Improvement Act ("HCQIA"), to the extent that a hospital defendant has met the notice and hearing requirements imposed by the Act and substantially prevails in a legal challenge to a professional peer review action it has taken, the court may award to it the costs of the suit, including reasonable attorneys' fees.
- E. All hearings and appellate reviews shall be conducted according to the procedural safeguards set forth in this Article to assure that the affected member is accorded all rights to which he/she is entitled.
- F. Definitions:
 - 1. Notice: All notices and requests provided for during the hearing and appellate review process shall be made in writing through the Chief Executive Officer by certified mail, return receipt requested, or by personal delivery.
 - 2. Date of Receipt: Shall mean the date on which notice or any other communication is received either personally or the date on the certified mail receipt.

3. Computation of Time: For the purposes of this Article, the day of receipt of notice or any other communication shall not be included in the computation of time. The last day of the time computed shall be included. If the time period is seven (7) days or less, the computation shall be business days; if the period is more than seven (7) days, the computation shall be calendar days. If the last day is a Saturday, Sunday or legal holiday, the period shall run to the next business day.

SECTION 2 - RIGHT OF MEDICAL STAFF MEMBER TO HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall constitute grounds for a hearing:

- denial of medical staff membership.
- denial of requested advancement in staff membership status, or category.
- denial of medical staff reappointment.
- demotion to lower medical staff category or membership status.
- suspension of staff membership.
- revocation of staff membership.
- denial of requested clinical privileges (excluding temporary privileges).
- involuntary reduction of current clinical privileges (excluding temporary privileges).
- suspension of clinical privileges (excluding temporary privileges).
- termination of all clinical privileges (excluding temporary privileges).
- involuntary imposition of consultation, co-admission or monitoring requirements (excluding monitoring incidental to provisional status) or involuntary imposition of requirements of additional education or personal counseling.

SECTION 3 - REQUEST FOR HEARING

- A. In all cases described in Section 2 of this Article, the affected member shall be promptly notified as provided in this Article of the adverse recommendation or action, the reasons for the recommended action, the right to request a hearing pursuant to this Section and the time within which to request a hearing, and given a summary of the member's rights during the hearing.

- B. The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Staff Executive Committee or the Governing Body, as appropriate. If the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and appellate review to which he/she is entitled, and to have accepted the recommendation or action involved. Such action or recommendation shall then become effective against the member pending final action by the Governing Body. The Chief Executive Officer shall promptly notify the member that recommendation has been made by the Medical Staff Executive Committee to the Governing Body.

SECTION 4 - NOTICE OF HEARING

- A. Within fourteen (14) days after receiving a request for a hearing from a member, the Medical Staff Executive Committee or the Governing Body, whichever is appropriate, shall, through the Chief Executive Officer, notify the member of the time, place and date of the hearing. The hearing date shall be scheduled not less than thirty (30) nor more than forty-five (45) days from the date of the notice to the member.
- B. The notice of hearing shall state clearly and concisely the acts or omissions with which the member is charged, 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, and shall contain a list of the witnesses who are expected to testify at the hearing on behalf of the recommendation.
- C. The hearing may be postponed or extended by the member beyond the times provided in these Bylaws only with approval, and at the sole discretion, of the Hearing Committee upon a showing of good cause. The Hearing Committee may postpone the hearing beyond the time provided in these Bylaws for good cause shown with the concurrence of the member.

SECTION 5 - HEARING COMMITTEE

The Chief of Staff shall appoint a Hearing Committee when he/she receives a request for a hearing from a member. The Hearing Committee shall be composed of at least five (5) members, and alternates as appropriate, of

the Active Medical Staff in good standing who are not on either the Medical Staff Executive Committee or the Governing Body. The Chief of Staff shall appoint one of the members as Chairperson. No Committee member shall be in direct economic competition with the affected member, or have actively participated in considering the matter that is the subject of the hearing, unless the size of the Active Medical Staff is too small, in which case, members of other categories may be selected. The Chief of Staff may, at his/her discretion, appoint additional members to the Hearing Committee as deemed necessary to attain a Peer Committee as to the specialty or privileges of the affected member.

SECTION 6 - PREHEARING PROCEDURE

- A. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive at least 15 days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Staff Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the Hospital or Medical Staff, and all evidence which will be made available to the Hearing Committee.
- B. The Medical Staff Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his or her possession or control.
- C. The Chairperson of the Hearing Committee shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Chairperson shall consider:
 - 1. whether the information sought may be introduced to support or defend the charges;
 - 2. the nature of the information sought, and whether it has a tendency to support or refute the charge or offense which is the subject of the hearing;
 - 3. the burden imposed on the party in possession of the information sought, if access is granted; and

4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- D. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Hearing Committee members. Challenges to the impartiality of any Hearing Committee member shall be ruled on by the Hearing Committee Chairperson, except for challenges made to the Hearing Committee Chairperson. Challenges to the impartiality of the Hearing Committee Chairperson shall be ruled on by the Chief of Staff.

SECTION 7 - CONDUCT OF HEARING

- A. The purposes of the Hearing are:
1. to determine the facts involved in the charge,
 2. to determine if the charge is supported by the evidence, and
 3. to determine if the requested action is appropriate to the charge, based on the evidence.
- B. There shall be at least three (3) members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.
- C. An accurate record of the hearing must be kept. The Committee shall establish the mechanism, which may be a court reporter, electronic recording unit, or detailed transcription.
- D. A member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights to the hearing and to have accepted the adverse recommendation or decision involved. The recommendation or decision shall then become and remain effective against the member pending a final decision by the Governing Body.
- E. The member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of Alabama who is not also an attorney at law, and the Medical Staff Executive Committee or

Governing Body, as appropriate shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Staff Executive Committee or Governing Body may be represented by an attorney.

- F. The Chairperson of the Hearing Committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The presiding officer may take such action as may be deemed necessary if he/she determines that either side is not proceeding efficiently and expeditiously.
- G. The rules of law relating to the examination of witnesses or presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may at its discretion, order that oral evidence shall be taken only on oath or affirmation.
- H. Within reasonable limits, both parties shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. The member shall also be entitled to submit a written statement on any issue of fact or procedure before, during or after the hearing and such statement shall become part of the record. If the member does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.
- I. Except as provided in Section 9 of this Article, the Medical Staff Executive Committee or Governing Body, as appropriate, shall have the burden of proof by a preponderance of evidence to support its recommendation or action. The affected member shall then have the burden of persuading the Hearing Committee to support his/her position.
- J. The Hearing Committee may, without special notice, recess the hearing and reconvene it for the convenience of the participants or to obtain new or additional evidence. After presentation of all oral and written evidence, the hearing shall be closed. The Hearing Committee may then, at a convenient time, deliberate outside the

presence of the affected member.

- K. Within ten (10) days after closing the hearing, the Hearing Committee shall submit a written report and recommendation, together with the hearing record and all other documentation, to the Medical Staff Executive Committee or to the Governing Body, whichever is appropriate. A copy of the report shall be sent to the affected member. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Staff Executive Committee or decision of the Governing Body. The Medical Staff Executive Committee or Governing Body shall consider the Hearing Committee's report and recommendation, but shall not be bound by it. Notice of the recommendation or decision made or adhered to by the Medical Staff Executive Committee or Governing Body, as the case may be, following the hearing, shall be provided to the affected member.

SECTION 8 - APPELLATE REVIEW

- A. Within fourteen (14) days after notice of an adverse recommendation or decision made, or adhered to after a hearing, the affected member may by written notice to the Governing Body request an appellate review. The notice must state clearly and concisely the grounds for the appeal and the facts supporting it. If oral argument is desired, the notice must specifically request that it be permitted as part of the appellate review, otherwise, the appellate review shall be conducted only on the written record.
- B. If the member does not request appellate review in the time and manner provided, he/she shall be deemed to have waived his/her right to appellate review, and to have accepted such adverse recommendation or decision. The recommendation or decision shall then become effective immediately.
- C. The only grounds for appeal shall be:
1. failure to comply substantively with these Bylaws;
 2. that the recommendation or decision was arbitrary or capricious; or
 3. that the recommendation or decision was not supported by substantial evidence.

- D. Within fourteen (14) days after receipt of a request for appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall notify the affected member in writing. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the request. The date of the appellate review may be postponed by the Governing Body upon a showing of good cause.
- E. The appellate review shall be conducted by the Governing Body or by a duly appointed Appellate Review Committee of the Governing Body of not less than three (3) members. If the appellate review is of a decision of the Governing Body, the Appellate Review Committee will be an Ad Hoc Committee of three (3) members appointed by the Chief of Staff. The members shall be members in good standing of the Active Staff who are not in direct economic competition with the affected member and who have not participated in consideration of the matter during the process unless the size of the Medical Staff is too small, in which case, members of other categories may be selected. For the purposes of this Section, "Appellate Review Committee" shall mean the Governing Body or Appellate Review Committee as appropriate.
- F. The affected member shall have access to the record (and transcript, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she may be charged reasonable charges for copies of such material. Unless otherwise provided by law, this shall not include minutes or proceedings of Peer Review Committees, which are privileged by law. Both parties to the appeal shall be permitted to submit a written statement in support of their position specifying the facts and procedures in dispute and the reasons therefore. A copy of the statement shall be provided to the other party when it is received by the Chief Executive Officer. This statement shall be submitted to the Appellate Review Committee at least ten (10) days before the date scheduled for the appellate review.

New or additional evidence may be accepted by the Appellate Review Committee in its sole discretion and only if it can be shown that such information could not reasonably have been made available at the hearing. Both parties shall have the right to cross-examine concerning such additional or new information.

If oral argument has been permitted, both parties shall be present at the Appellate Review to make oral arguments and answer questions addressed to them by the Appellate Review Committee.

- G. The Appellate Review Committee shall review the record created in the proceedings, and shall consider the written statements to determine:
1. if there was a substantial failure to comply substantively with the Medical Staff Bylaws; or
 2. if the recommendation or decision was arbitrary or capricious; or
 3. if the recommendation or decision was not supported by substantial evidence.
- H. If an appellate review is conducted by the Governing Body, it may affirm, modify or reverse the prior decision, or in its discretion, refer the matter back to the Medical Staff Executive Committee for further review and recommendation within ten (10) days after the conclusion of the appellate review. If the matter is referred back to the Medical Staff Executive Committee, it may request that the Medical Staff Executive Committee arrange for a further hearing to resolve specific disputed issues. The Medical Staff Executive Committee shall make its report within thirty (30) days of such request.
- I. If the review is conducted by the Appellate Review Committee of the Governing Body, it shall within thirty (30) days of receipt of the request, either make a written report to the Governing Body recommending that the Governing Body affirm, modify or reverse the prior decision, or refer the matter back to the Medical Staff Executive Committee within ten (10) days for further review and recommendation. Such referral may include a request that the Medical Staff Executive Committee arrange for another hearing to resolve specific disputed issues. The Medical Staff Executive Committee's report shall be due within thirty (30) days after receiving the referral. Then within ten (10) days after receiving the Medical Staff Executive Committee's recommendation, the Appellate Review Committee shall make its recommendation to the Governing Body.
- J. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section have been completed or waived. Where permitted by the Board of Trustee Bylaws, all action

required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

SECTION 9 - FINAL DECISION BY GOVERNING BODY

Within thirty-five (35) days after receiving the Appellate Review Committee's recommendation, the Governing Body shall make its final decision on the matter and will send notice to the Medical Staff Executive Committee and to the affected member, as provided herein. Such notice of final action shall include a written decision containing a statement of the basis of the decision.

SECTION 10 - RIGHT OF PRACTITIONER APPLICANTS TO HEARING

- A. An applicant (non-member) to the Medical Staff, upon receiving notice of an adverse decision of the Governing Body on his/her application for membership or privileges, shall be entitled to a hearing before the Hearing Committee. The applicant shall request such hearing in writing within thirty (30) days of receipt of notice of the adverse decision. Failure of the applicant to request such hearing in the time and manner prescribed in this Article shall be deemed a waiver of the applicant's rights to such proceedings and acceptance of the Governing Body's decision as final.
- B. Within fourteen (14) days following receipt of a request for a hearing, the Governing Body shall through the Chief Executive Officer notify the applicant of the time, place and date of the hearing.
- C. The Hearing Committee shall be constituted as described in Section 5 of this Article.
- D. The Hearing Committee shall convene the hearing within not less than thirty (30) and not more than forty-five (45) days after giving notice to the applicant of the hearing. The hearing shall be conducted in the manner described in Section 6 of this Article. The Hearing Committee shall make a recommendation to the Governing Body within ten (10) days after closing the hearing. A copy of the recommendation shall be sent to the applicant. The applicant may also obtain a copy of the transcript of the hearing and may be charged reasonable charges for such copy.
- E. If the Hearing Committee's recommendation is still adverse to the applicant, the applicant may submit to the Governing Body a written

statement containing the objections to the recommendation, including any allegations of procedural errors. The applicant may make an oral statement to the Governing Body as well.

- F. The Governing Body shall consider the record of the hearing as well as the applicant's written and/or oral statements in addition to all the other material presented with the application. The Governing Body shall determine:
- I. if there was substantial failure to comply substantively with the Medical Staff Bylaws;
 2. if the initial decision was arbitrary or capricious; or
 3. if the initial decision was supported by substantial evidence.

The Governing Body shall consider the recommendation of the Hearing Committee and shall render its final decision within thirty (30) days after receiving the recommendation.

- G. The practitioner may waive his/her right to a hearing before the Hearing Committee and request a hearing before the Governing Body. The Governing Body's decision will be final.

SECTION 11 - RIGHT OF ALLIED HEALTH PROFESSIONAL TO A HEARING

- A. Triggering event – the following recommendation or actions shall, if deemed adverse under 11(B) below, entitle the practitioner to appeal under timely and proper request:
- 1) denial or restriction of requested clinical privileges;
 - 2) reduction of clinical privileges
 - 3) suspension of clinical privileges
 - 4) revocation of clinical privileges
- B. When deemed adverse – a recommendation or action listed in 11(A) above is adverse only when it has been:
- 1) recommendation by the Medical Staff Executive Committee to the Board of Trustees;
 - 2) acted upon by the Board of Trustees

C. Notice of adverse recommendation or action - The Chief Executive Officer (CEO) shall promptly give the practitioner special notice of an adverse recommendation or action taken pursuant to 11(A). The notice shall do the following:

- 1) Advise the practitioner of the recommendation or action and of his/her rights to request an appeal pursuant to the provisions of this policy by certified mail. *Note – if practitioner is sponsored by a physician member of the Medical Staff, that member shall also be notified of the recommendation by certified mail.*
- 2) Specify that the practitioner has fourteen (14) days after receiving the notice within which to submit a request for an appeal;
- 3) State that as part of the appeal the practitioner involved has the right to received an explanation of the decision made and to submit any additional information the practitioner deems relevant to the review and appeal of this decision;
- 4) State upon completion of the appeal, the practitioner involved has the right to receive a written decision, including a statement of the basis of the decision.

D. Request for appeal – the practitioner will have fourteen (14) days after receiving notice under 11(C) to file a request for an appeal. The request must be delivered to the CEO either in person or by certified or registered mail. The appellate hearing will be within six (6) days.

E. Waiver by failure to request an appeal – a practitioner who fails to request an appeal within the time, and in the manner specified in 11(D) waives his or her right to an appeal to which he or she might have been entitled. Such waiver applies only to the manners that were the basis for the adverse recommendation or actions triggering the notice referenced in 11(C) above.

F. Appeal procedure – when a practitioner requests an appeal, the appeal shall consist of a single meeting attended by the practitioner, the CEO, the Chief of Staff and Department Chief. During the meeting, the basis of the decision adverse to the practitioner which gave rise to the appeal will be reviewed with the practitioner, and the practitioner will have the opportunity to present any additional information the practitioner deems relevant to the review and appeal the decision. Following the meeting, the CEO, the Chief of Staff and Department Chief will make a recommendation to the Medical Staff Executive Committee which will then determine whether the adverse decision will stand, be modified, or be reversed. The

practitioner will receive a written decision of the Medical Staff Executive Committee stating the result of the appeal and the basis of the decision by certified mail.

G. Sole remedy—this appeal will be the sole remedy available to a practitioner who experiences an adverse decision defined in 11(B) above and qualified for this appeal.

H. Practitioner's right to legal counsel – nothing in this plan shall be deemed to deny a practitioner the right to engage or be advised by legal counsel. However, legal counsel may not be present at the appeal meeting.

ARTICLE IX

ELECTED OFFICERS

SECTION 1 - OFFICERS OF THE MEDICAL STAFF

- A. The officers of the Medical Staff shall be the:
1. Chief of Staff.
 2. Vice Chief of Staff.
 3. Secretary-Treasurer
 4. Chief of Surgery
 5. Chief of Medicine
 6. Two Representatives-at-Large who represent hospital-based Departments.
 7. Immediate Past-Chief of Staff
 8. Chief of Emergency Services

SECTION 2 – QUALIFICATIONS/REMOVAL OF OFFICERS

Licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of the organized medical staff. Officers must be members of the Active Staff in good standing at the time of nomination and election and must remain in good standing during their terms of office. Failure to maintain such status shall immediately terminate the officer's term. Officers may also be removed from office for failure to perform the duties of the office. Conditions for removal include an officer accused of contrived gross, or willful neglect of the duties of his/her office, or any failure in conduct or other qualifications which might also impair or result in suspension or revocation of privileges or membership on the medical staff.

SECTION 3 - NOMINATION OF OFFICERS

- A. The Nominating Committee shall prepare a list of one or more nominees for the offices of Vice Chief of Staff, Secretary-Treasurer, and two or more Representatives-at-Large.
- B. The Nominating Committee shall accept suggestions of potential nominees from the Medical Staff 60 days prior to the annual meeting.

- C. Nominations may be made from the floor.

SECTION 4 - ELECTION OF OFFICERS

- A. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Staff present at the meeting shall be eligible to vote.
- B. The official ballot shall specify which nominees are offered by the Nominating Committee and by petition. Voting shall be by secret ballot and officers shall be elected by majority vote. When there are three (3) or more nominees for an office and no candidate receives a majority on the ballot, the name of the nominee receiving the fewest votes will be omitted from each successive ballot until a majority vote is obtained for one nominee.
- C. The Chief of Staff-Elect and three (3) other members of the Medical Staff named by the Chief of Staff-Elect shall serve as Tellers. The Tellers shall determine the procedure to be followed in counting the ballots.
- D. If there is no quorum at the annual meeting, the offices shall be considered vacant and shall be filled according to Section 6 of this Article.

SECTION 5 - TERM OF OFFICE

- A. Except as otherwise provided in these Bylaws, officers shall serve terms as follows: The Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of the Medical Staff, the Secretary- Treasurer, Chief of Surgery, Chief of Medicine and Representatives at Large shall serve a two (2) year term. Each term shall begin the first day of the new Medical Staff year after election, or upon taking office, and shall end on the last day of the Medical Staff year at the expiration of the officer's terms, or until their successors take office (whichever occurs last). An officer must be out of office for one (1) year before being eligible to be nominated for another term in the same office. This does not preclude nomination of such officer to another office.
- B. Officers of the Medical Staff may be recalled for grounds specified under Article VII, Section B, upon presentation to the Chief of Staff of a petition signed by thirty percent (30%) of the Active Staff members. Within twenty (20) days of receipt of a petition, the Chief of Staff shall

verify the signatures and call a special meeting of the Medical Staff to vote on the recall. An officer shall be recalled and removed from office upon a vote of not less than one-half of the Active Staff membership present at the meeting. The vote shall be by secret written ballot.

SECTION 6 - VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled immediately by the Medical Staff Executive Committee. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term. If there is no Chief of Staff-Elect, the Medical Staff Executive Committee shall fill the vacancy.

SECTION 7 - DUTIES

- A. Chief of Staff - Shall serve as chief administrative officer of the Medical Staff to:
1. Interact with the Medical Staff Executive Committee and Governing Body in all matters of mutual concern within the hospital, and on the effectiveness of the Quality Assurance Program, the clinical performance and quality patient care of the Medical Staff related to its delegated responsibility to provide quality patient care.
 2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
 3. Chair the Medical Staff Executive Committee and serve as a member of the Joint Conference Committee, as described in Article III, Section 4.
 4. Serve as an Ex-Officio member of all other Medical Staff committees.
 5. Be responsible for enforcing the Medical Staff Bylaws and Rules and Regulations, for implementing sanctions where they are indicated, and for the Medical Staff complying with the procedural safeguards in all disciplinary proceedings.
 6. Appoint Committee Chairpersons and members to all standing and other committees of the Medical Staff except as provided in these Bylaws.

7. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and the Chief Executive Officer.
 8. Be responsible for the continuing education activities of the Medical Staff; and
 9. Represent the Medical Staff in its external professional and public relations.
 10. Appoint replacements for Medical Staff Committee members elected at large who are no longer able to serve.
- B. Vice Chief of Staff - In the absence of the Chief of Staff, he/she shall assume the duties and the authority of the Chief of Staff. He/she shall be a member of the Medical Staff Executive Committee and the Joint Conference Committee. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.
- C. Secretary-Treasurer - He/she shall be a member of the Medical Staff Executive Committee. The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings pursuant to these Bylaws, attend to all the correspondence and perform such other duties as ordinarily pertain to his/her office.
- D. Chief of Surgery - He/she shall be a member of the Medical Staff Executive Committee. Account to the Medical Staff Executive Committee for all professional and administrative activities within his/her Department and particularly for the quality of patient care rendered by members of the Department and the effective conduct of the performance evaluation and other quality assurance functions delegated in his Department.
- E. Chief of Medicine - He/she shall be a member of the Medical Staff Executive Committee. Account to the Medical Staff Executive Committee for all professional and administrative activities within his/her Department and particularly for the quality of patient care rendered by members of the Department and the effective conduct of the performance evaluation and other quality assurance functions delegated in his Department.
- F. Immediate Past Chief of Staff - The Immediate Past Chief of Staff shall be a member of the Medical Staff Executive Committee and the

Nominating Committee and shall perform such other advisory duties as are assigned to him/her by the Chief of Staff or the Medical Staff Executive Committee.

- G. Representatives-at-Large - The Representatives-at-Large shall be members of the Medical Staff Executive Committee. They shall also perform such duties as are assigned to them by the Chief of Staff.
- H. Chief of Emergency Services - He/she shall be a member of the Medical Staff Executive Committee. Account to the Medical Staff Executive Committee for all professional and administrative activities within his/her Department and particularly for the quality of patient care rendered by members of the Department and the effective conduct of the performance evaluation and other quality assurance functions delegated in his Department.

ARTICLE X

MEETINGS

SECTION 1 - THE ANNUAL MEETING

The annual meeting of the Medical Staff shall be in October of each year. At this meeting, the Nominating Committee shall present the slate of nominees for Officers. Officers for the ensuing term shall be elected and installed. This meeting shall include a business session in which all Departments and Committees may present an annual report.

SECTION 2 - GENERAL DEPARTMENTAL MEETINGS

Regular meetings of the Medical Staff shall be held at least 4 times a year at a time and place designated by the Medical Staff Executive Committee.

SECTION 3 - SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Governing Body, the Medical Staff Executive Committee, or by the joint written request of at least twenty-five percent (25%) of the Active Staff. At any special meeting no business shall be transacted except that stated in the notice of the meeting.

SECTION 4 - ATTENDANCE AT MEETINGS

Except as provided in this Section, and Section 6 of this Article, Staff members shall be encouraged to attend at least one-third (1/3) of scheduled meetings. An absence may be excused by the Chief of Staff or the Chief Executive Officer for good cause. Courtesy, Consulting and Honorary Staff members are not required to attend meetings, but are expected to do so when possible.

SECTION 5 - QUORUM

Twenty-five percent (25%) of the voting membership of the Staff shall constitute a quorum for the transaction of all Staff business, except as outlined in Article IX, Section 5, B.

SECTION 6 - MANNER OF ACTION

The action of a majority of members present and voting at a meeting at which a quorum is present shall be the action of the Medical Staff.

SECTION 7 - CLINICAL PRESENTATIONS

If a case is to be discussed at a meeting because of problems found either during routine case review, or otherwise, the affected member shall be notified and shall be present when the case is discussed. The member shall not unreasonably refuse to attend. The case may be presented in the member's absence unless the absence is excused and the member has requested that discussion be postponed. Discussion shall not be postponed later than the next regular meeting. In peer review, the practitioner may be present to discuss the case but should be excused before any deliberations or voting occur.

SECTION 8 - ORDER OF BUSINESS AND AGENDA

The meeting shall be conducted according to Roberts Rules of Order as last amended. The agenda shall include at least:

- A. Reading and acceptance of the minutes of the last regular meeting and of all special meetings held since the last regular meeting;
- B. Administrative reports from the Chief Executive Officer, the Chief of Staff, Department Chiefs, and Committee Chairpersons;
- C. The election of officers, when required by these Bylaws;
- D. Reports by responsible Officers, Committees, and Departments on the overall results of patient care audits and other quality improvement activities of the Staff and on the fulfillment of any required Staff functions;
- E. Recommendations for improving patient care within the Hospital.

The agenda at special meetings shall be:

- A. Reading of the notice calling the meeting, and
- B. Transaction of the business for which the meeting was called.

SECTION 9 - MINUTES

Minutes of all General Staff meetings shall be prepared by the Secretary-Treasurer and shall include a record of attendance and the vote taken on each matter. The minutes shall be signed and copies made available to the Staff. The Chief Executive Officer shall maintain a permanent file of the minutes of each meeting.

SECTION 10 - MEETING AS A COMMITTEE-OF-THE-WHOLE

Notwithstanding any other provision of these Bylaws, whenever the Medical Staff of a Department or Service meets, it shall be considered to be meeting as a Committee-of-the-whole Medical Staff, Department, or Service, respectively.

SECTION 11 - CONFIDENTIALITY

All meetings shall be open to any member of the Medical Staff. Meeting Chairpersons may close a portion of any meeting if in their judgment the best interest of the Medical Staff is served by this closure.

ARTICLE XI

DEPARTMENTS OF THE MEDICAL STAFF

SECTION 1 - DEPARTMENTS

- A. The current Departments of the Staff are as set forth below. When appropriate, the Medical Staff Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Departments.
1. Department of Medicine (to include Internal Medicine, Gastroenterology, Nephrology, Endocrinology, Allergy, Cardiology, Dermatology, Pulmonary Medicine, Neurology, Hematology, Pediatrics, Oncology, Emergency Medicine, Radiology and Family Practice).
 2. Department of Surgery (to include Oral Surgery and General Dentistry, Ophthalmology, Protocology, Thoracic, Plastic, Otorhinolaryngology, Neoplastic, Traumatic Surgery, Orthopedics, Neurosurgery, Cardiovascular, Anesthesiology, Pathology, Podiatry, Pain Management, Urology, and GYN).
- B. Other Departments may be established from time to time upon the written request to the Medical Staff Executive Committee by the membership of the Active Staff or a Department and upon approval of the Medical Staff Executive Committee and Governing Body. No Department may be established or maintained with less than three (3) Active Staff members, except Hospital-based Departments.
- C. An approved and authorized Department may be eliminated if the Medical Staff Executive Committee and Governing Body determine that the patient activity of the Department or Section has decreased so that it is not substantial enough to warrant such status or the number of Active Staff members decreases to less than three (3), except Hospital-based Departments.

SECTION 2 - ORGANIZATION OF DEPARTMENTS

Each Department shall be organized as a separate part of the Medical Staff and shall have a Chief who is elected and has the authority, duties and responsibilities as specified in this Article.

SECTION 3 - ASSIGNMENT TO DEPARTMENTS

Each member of the Staff shall be assigned to not more than one (1) Department but may be granted clinical privileges in one (1) or more Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of that Department and the authority of the Department Chief.

Allied Health Professionals, regardless of source of employment and degree of practice independence shall be assigned to a Department where their clinical performance shall be monitored. They shall be subject to all applicable rules and regulations of the Department and authority of the Department Chief .

SECTION 4 - FUNCTIONS OF DEPARTMENTS

- A. The primary responsibility of each Department is to implement and conduct specific monitoring review and evaluation activities that preserve and improve the quality and efficiency of patient care provided in the Hospital.
- B. To carry out this responsibility, each Department shall:
 - 1. Conduct ongoing monitoring to analyze, review and evaluate the quality and efficiency of care within the Department based on objective criteria reflecting current knowledge and clinical experience. This function shall be designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served:
 - a. ability to obtain information and interpret information in terms of the patients' needs;
 - b. a knowledge of growth and development; and
 - c. an understanding of the range of treatment needed by these patients.

Each department shall review all clinical work performed under its jurisdiction whether or not the practitioner is a member of the Department. The Department shall also identify actions to be taken to resolve identified problems through the Ongoing

Professional Practice Evaluation and Focused Professional Practice Evaluation processes.

2. Establish criteria for granting clinical privileges in the Department and submit the recommendations required under these Bylaws regarding the specific privileges to be granted to each Staff member or applicant and each allied health professional affiliate. Cross-specialty privileges may cross departmental lines. Departments can recommend privilege criteria but they should not establish them since criteria should be privilege specific and not department specific.

Clinical privileges shall be based upon demonstrated and relevant training and experience, current licensure (to include restricted DEAs), current competencies as listed by The Joint Commission, and the ability to perform the privileges requested within the specialty covered by the Department.

3. Conduct or participate in, and recommend continuing education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.
4. Monitor on a continuing and concurrent basis, adherence to: a) Staff Bylaws, Rules and Regulations; b) requirements for alternate coverage and consultations; and c) sound principles of clinical practice.
5. Coordinate the patient care provided by the Department's members with nursing and ancillary services and administrative support services.
6. Foster an atmosphere of professional decorum within the Department appropriate to the healing arts.
7. Submit written reports to the Medical Staff Executive Committee on a regularly scheduled basis concerning: a) findings of the Department's review and evaluation activities, action taken thereon and the results of such action; b) care provided in the Department and the Hospital; and c) proctoring component of FPPE which is the responsibility of the department. and; d) such other matters as may be requested from time to time by the Medical Staff Executive Committee.

8. Meet at least 4 times a year to receive, review and consider patient care review findings and the results of the Department's other monitoring, evaluation and education activities and to perform or receive reports on other Department and Staff functions.
 9. Establish such Committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.
 10. Establish written rules and regulations, if applicable, for the organization, operation and function of the Department that do not conflict with the Medical Staff Bylaws and Rules and Regulations. The Rules and Regulations must be reviewed annually and any additions, deletions, revisions or changes must be approved by the Medical Staff Executive Committee and ratified by the Governing Body.
 11. Provide information or recommendations regarding new procedures at the request of the Credentials Committee and/or Medical Staff Executive Committee.
 12. Completion of an orientation program provided by the Medical Staff Services Department including introductions to all appropriate Hospital supervisory personnel.
- C. Members of each Department may be called upon for assignment of patients at the request of the Department Chief or the Chief of Staff.

SECTION 5 - QUALIFICATIONS, ELECTION AND TENURE OF DEPARTMENT CHIEF

- A. Each Department shall have a Chief who shall be a member in good standing of the Active Staff and the Department, shall be Board Certified or qualified by training, experience, interest and demonstrate current ability in the clinical area covered by the Department, and shall be willing and able to discharge the administrative responsibilities and functions of the office.
- B. Each Department Chief shall be elected subject to approval of the Medical Staff Executive Committee.
- C. Each Department Chief, except as otherwise provided in these

Bylaws, shall serve a two (2) year term commencing on the first day of the new Medical Staff year. He/she shall serve until the end of the succeeding Medical Staff year or until his/her successor takes office, whichever is later. A Department Chief shall not be eligible to succeed himself/herself. A Department Chief may be removed from office by the Chief of Staff, upon the recommendation of the Medical Staff Executive Committee, or upon a vote of not less than one-half of the Active Staff membership present at the meeting.

- D. Each Department shall elect a Vice-Chairperson. The Vice-Chairperson shall assume the duties and authority of the Chairperson in his/her absence and be responsible for such duties as may be assigned by the chairperson. The Vice Chairperson shall serve the same term as the Chairperson and may be removed in the same manner as the Chairperson or by the Chairperson.

SECTION 6 - DUTIES OF DEPARTMENT CHIEF

The duties of the Department Chief are as follows:

- A. Account to the Medical Staff Executive Committee for all professional and administrative activities within his/her Department and particularly for the quality of patient care rendered by members of the Department and the effective conduct of the performance evaluation and other quality assurance functions delegated in his Department.
- B. Develop and implement Departmental programs to review credentials and delineate privileges, orientation, continuing medical education, utilization review, provide for planned, systematic ongoing monitoring of appropriateness of care and other quality assurance functions as required by these Bylaws.
- C. Serve on the Medical Staff Executive Committee, give guidance on the overall medical policies of the hospital, and make specific recommendations and suggestions regarding his own Department.
- D. Continuously review the professional performance of all practitioners and Allied Health Professional affiliates with clinical privileges in the Department and report monthly thereon to the Medical Staff Executive Committee. This is to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within medical staff departments, across departments, and between members and nonmembers of the medical staff who have delineated clinical privileges.

- E. Transmit the Department's recommendations concerning appointment and Staff category, reappointment, delineation of clinical privileges or specific services, and disciplinary action with respect to practitioners in the Department.
- F. Appoint such Committees as are necessary to conduct the functions of the Department and designate a Chairperson and Secretary for each.
- G. Enforce the Medical Staff Bylaws and Rules and Regulations; policies and department rules and regulations including initiating disciplinary action and investigation of clinical performance and ordering consultations.
- H. Implement Medical Staff Executive Committee actions in the Department.
- I. Participate in every phase of Department administration with the nursing service and the hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
- J. Assist in the preparation of annual reports, including budget planning, pertaining to the Department as may be required by the Medical Staff Executive Committee, the Chief Executive Officer, or the Governing Body.
- K. Integrate the department/service into the primary functions of the Medical Staff; coordinate and integrate interdepartmental and intradepartmental services; make a recommendation as to the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- L. Perform such other duties as may from time to time be reasonably requested by the Chief of Staff, the Medical Staff Executive Committee, the Chief Executive Officer or the Governing Body.
- M. Oversee assessing and recommending to the relevant hospital authority off-site sources needed for patient care, treatment, and services not provided by the department or the organization.
- N. Oversee the development and implementation of policies and

procedures that guide and support the provision of care, treatment, and services.

- O. Oversee maintaining quality control programs, as appropriate.
- P. Make recommendations for space and other resources as needed by the department or service.
- Q. Makes recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- R. Responsible for the continuous assessment and improvement of the quality of care, treatment and services.
- S. Responsible for the orientation and continuing education of all persons in the department or service.

ARTICLE XII

DEPARTMENT MEETINGS

SECTION 1 - SCHEDULED REGULAR MEETINGS

A regular meeting of each Department shall be held at least 4 times a year to review and evaluate the clinical work of practitioners and affiliates with privileges in the Department. The meeting shall include at least a thorough review of work done in the Department with emphasis on utilization review, quality assurance, risk management and morbidity and mortality analysis.

SECTION 2 - SPECIAL MEETINGS

The Department Chief may call special meetings or convene special Department Committees as he/she deems necessary to accomplish the purposes of the Department.

SECTION 3 - QUORUM

Twenty-five percent (25%) of the Active Staff members of a Department (or Section thereof), but not less than two (2) members, shall constitute a quorum at any meeting except for Hospital-based Departments.

SECTION 4 - MINUTES

Minutes of each Department or Section meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be reviewed, approved, and signed by the presiding officer. The permanent file for all Department meetings shall be maintained in the Chief Executive Officer's office.

SECTION 5 - MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of that Department

SECTION 6 - ATTENDANCE REQUIREMENTS

- A. Each member of the Active and Associate Staff shall be encouraged to attend all meetings of each Department of which he/she is a member in each Medical Staff year.

- B. A member of the Medical Staff whose patient's clinical case is scheduled for discussion at a Department (or Section) meeting shall be so notified and shall be expected to attend such meeting. If the member is not otherwise required to attend the Department meetings, the Chief of Staff shall, through the Chief Executive Officer, give the member advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the member shall so state, shall be delivered by certified mail, return receipt requested, and shall include a statement that attendance at the meeting is mandatory.
- C. Failure of a member to attend any meeting of which he/she was given notice of mandatory attendance or who fails to comply promptly with appropriate requests of duly constituted Committees for cooperation and assistance, including but not limited to letters from duly constituted Committees or Departments, unless excused by the Chief of Staff or Department Chief upon a showing of good cause, may be cause for disciplinary action. In all cases, if the member shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the Chairperson until not later than the next regular meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE XIII

COMMITTEES

The Committees of the Medical Staff shall consist of Standing Committees and Other Committees, the latter appointed on an ad hoc basis. The Standing Committees of the Medical Staff shall be as follows: Medical Staff Executive; Credentials; Nominating; Health Information Management; Pharmacy, Therapeutics and Blood Utilization Review; Infection Control; Radioisotope; Emergency Care; Bylaws; Critical Care; Continuing Medical Education; Joint Conference, Physician Health and Other Committees.

The Chief of Staff and/or the Chief-Elect and the Chief Executive Officer or his/her designee shall be ex-officio members of all Committees unless otherwise designated.

The Chief of Staff shall, after consultation with the Medical Staff Executive Committee, appoint members to all standing Committees except the Medical Staff Executive Committee unless otherwise provided in these Bylaws.

All Committee members are expected to attend their Committee meetings and failure to attend fifty percent (50%) of the meetings may result in disciplinary action at the discretion of the Medical Staff Executive Committee.

Minutes of all Committee meetings shall be transcribed and maintained in the office of the Chief Executive Officer.

SECTION 1 - MEDICAL STAFF EXECUTIVE COMMITTEE

- A. Composition: The Medical Staff Executive Committee shall consist of the Officers of the Medical Staff (page 54). The Chief of Staff shall serve as Chairperson.

The Chief Executive Officer will serve as an ex-officio non-voting member of the Medical Staff Executive Committee. During executive sessions of the Medical Staff Executive Committee, the Chief Executive Officer or his designee, if they had been invited to attend, may be invited to stay or may be asked to leave the meeting.

No active medical staff member actively practicing in the hospital is

ineligible for membership on the Medical Staff Executive Committee solely because of his or her professional discipline or specialty.

B. Duties: The duties of the Medical Staff Executive Committee shall be designated as follows:

Medical Staff Executive Committee (MSEC) Duties

1. To represent, respond to and act on behalf of the Medical Staff subject to any limitations imposed by these Bylaws. MSEC is empowered to act for the organized medical staff between meetings of the organized medical staff.
2. To manage the affairs, organization, and structure of the Medical Staff, and to enforce Medical Staff Bylaws, Rules, Regulations, and Policies.
3. To coordinate the activities and general policies of the services, committees and/or departments as required.
4. To receive, review, evaluate and act upon reports of the Medical Staff Committees.
5. Develop a mechanism used to review the report and recommendations of the Credentials Committee regarding applicants for appointment, reappointment, advancement or changes in Staff category, delineation of clinical privileges and/or assignments to services and make recommendations directly to the Governing Body for appointment/reappointment to the medical staff, advancement or changes in staff category, assignments to services, and delineation of clinical privileges. The committee may request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.
6. To implement policies of the Medical Staff.
7. To take all reasonable steps to ensure professional and ethical conduct by all members of the Medical Staff and to initiate and/or participate in Medical Staff disciplinary action or reviews as indicated.
8. To provide liaison among the Medical Staff, the Chief Executive Officer, the Governing Body and the Corporation.

9. To recommend action to the Chief Executive Officer on medico-administrative matters.
10. To make recommendations on Hospital management matters, such as long-range planning to the Governing Body through the Chief Executive Officer.
11. To fulfill the Medical Staff's accountability to the Governing Body for the quality of the medical care rendered to the patients in the Hospital.
12. To ensure that the Medical Staff is kept informed of the accreditation program and status of the Hospital.
13. To prepare the programs of all meetings, either directly or through a program committee or other suitable agent.
14. To report at each regular and annual Medical Staff meeting.
15. Organize the Medical Staff's organization performance improvement activities and establish a mechanism to conduct, evaluate and revise such activities.
16. The Medical Staff Executive Committee has a leadership role in the organization performance improvement activities designed to: Ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, but are not limited to those within the:
 - a) Medical assessment and treatment of patients
 - b) Use of medications
 - c) Use of blood and blood components
 - d) Use of operative and invasive procedures
 - e) Efficiency of clinical practice patterns (relationship between outcomes and the resources used to deliver care)
 - f) Significant departures from established patterns of clinical practice.
17. To evaluate and make recommendations for improvement of education for patients and family.
18. Assure the coordination of care with other practitioners and

hospital personnel, as relevant to the care, treatment and services of the individual patients.

19. Develop a mechanism by which medical staff membership may be terminated.
 20. Create the mechanism for use in fair hearing procedures.
- C. Meetings: The Medical Staff Executive Committee shall meet at least once a month (except when necessary) and maintain a permanent record of its proceedings and actions. The Department Chief, or the Vice Chairperson in his/her stead, shall be required to attend Medical Staff Executive Committee meetings.
- D. Medical Staff Executive Committee votes that do not involve disciplinary action, action regarding an individual member, action regarding privileges or action that is not deemed sensitive, shall be recorded and publicly posted.

SECTION 2- CREDENTIALS COMMITTEE

- A. Composition: The Credentials Committee shall consist of the Vice Chief of Staff, Chief of each Department and a chairman appointed by the Chief of Staff and at least two practitioners selected from the Medical Staff by the Chief of Staff.
- B. Duties: The duties of the Credentials Committee shall be:
1. To review the report and recommendations of the Department Chiefs regarding all applicants for membership to the Staff to ensure that all investigations were pursued with total objectivity, fairness, and impartiality and that the recommendations are soundly based and compatible with the established criteria, needs and objectives of the Medical Staff and Hospital.
 2. To make a report and recommendations to the Medical Staff Executive Committee of the Medical Staff regarding each applicant for Staff membership in conformity with Article IV of these Bylaws.
 3. To review the report and recommendations of the Department Chiefs regarding the competence of Staff members and, as a result of such review, to make a report and recommendations to the Medical Staff Executive Committee of the Medical Staff

regarding clinical privileges to be granted, reappointments, the assignment of members to the various Sections and Departments, and changes or advancements in Staff category as provided for in these Bylaws.

4. To investigate any breach of ethics that may be reported by the Medical Staff Executive Committee and to transmit its findings and recommendations to the Medical Staff Executive Committee.
5. The Committee shall be responsible for the development and maintenance of appropriate protocol whereby suspected or potential mentally or physically impaired members of the Medical Staff may be reviewed and the results of such review be transmitted as appropriate to the Credentials Committee, Medical Staff Executive Committee, or Governing Body upon a request by any Chairperson, the Chief of Staff or the Moderator of the Governing Body. Specifically, the Committee's duties shall be:
 - a. To appoint an appropriate panel of physicians in cooperation with the Chief of Staff to conduct such review.
 - b. To conduct an initial interview with the referred member and schedule an examination of the referred physician with the panel of physicians; arrange for second opinions when requested by the examining physician panel or by the referred physician; and arrange for laboratory tests as requested by the panel of physicians.
 - c. To keep the body that requested review informed of the progress of the examination.
 - d. To recommend policies and procedures to the Medical Staff Executive Committee pertaining to the impaired physician program.
 - e. Any physician absent from the medical staff for medical reasons should provide the Chief of Staff a health statement from attending physician.
6. To review all new procedures and to make report and recommendation to the Medical Staff Executive Committee

regarding new procedure prior to the procedure being performed. The Credentials Committee may ask for information/recommendations from appropriate Departments.

- C. Meetings: The Credentials Committee shall meet as needed, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Staff Executive Committee of the Medical Staff.

SECTION 3 - NOMINATING COMMITTEE

- A. Composition: The Committee shall consist of the Chief of Staff, the Immediate Past Chief and three (3) members of the Active Staff who have been elected from the floor.
- B. Duties: The Committee shall prepare and recommend a slate of nominees for the offices of the Chief of Staff, Chief of Staff-Elect, Secretary-Treasurer and two or more Representatives-at-Large.
- C. Meetings: The Nominating Committee shall meet biannually, at least sixty (60) days before the annual meeting and maintain a permanent record of its proceedings and actions. The Nominating Committee shall report its recommendations to the Chief Executive Officer and the Medical Staff Executive Committee.

SECTION 4 - HEALTH INFORMATION MANAGEMENT COMMITTEE

- A. Composition: The Health Information Management Committee shall consist of five (5) representatives selected from the Medical Staff, Health Information Management Director, and personnel from Nursing and Administration.
- B. Duties: The duties of the Health Information Management Committee shall be to:
 - 1. Make recommendations for the establishment of standards within the policies of the Hospital for the timely maintenance of complete medical records including all requirements of applicable regulatory and accrediting agencies.
 - 2. Review, analyze, and evaluate the quality of medical records in the Hospital for their timely completion, clinical pertinence and overall adequacy for use in quality assessment activities and

- when necessary as medico legal documents.
3. Report material discrepancies revealed by its review and recommend appropriate educational and corrective actions.
 4. Determine and approve the format of the complete medical record, the forms used in the record and the use of microfilm.
 5. Act in such related matters as may be assigned to it by the Medical Staff Executive Committee or the Chief of Staff.
- C. Meetings: The committee shall meet at least quarterly, but whenever required, keep minutes of all such meetings, and written reports of all evaluations performed and actions taken to the Medical Staff Executive Committee.

SECTION 5 - PHARMACY, THERAPEUTICS AND BLOOD UTILIZATION COMMITTEE

- A. Composition: The Committee shall consist of at least four members from different clinical departments, and representatives of Administration, Pharmacy and Nursing Services.
- B. Duties: The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital to achieve optimum clinical results and a minimum potential for hazard. Specifically, the Committee's duties shall be:
1. To assist in formulating broad professional policies regarding the drug evaluation, selection, procurement, distribution, use, safety procedures, evaluation of reported drug reactions and other matters relating to drugs in the hospital.
 2. To advise the Medical Staff and Administration on matters pertaining to the choice of drugs.
 3. To develop a Hospital Formulary or drug list of accepted drugs for use in the hospital and to add or delete from the list of drugs accepted for use in the hospital.
 4. To prevent unnecessary duplication in the stock of the same basic drug and its preparation.
 5. To make recommendations concerning drugs to be stocked in

- the nursing units and by other services.
6. To evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
 7. To review untoward drug reactions and medication errors.
 8. To perform drug use reviews and antibiotic reviews.
 9. To review the use of any investigational drugs.
 10. To evaluate clinical practice objectively for compliance with the criteria for the use of whole blood and each of its components administered in the Hospital.
 11. To evaluate untoward transfusion reactions. In addition, the Committee shall strive to assure the adequate reporting of actual or suspected transfusion reactions, including the recommendation of periodic inservice training for nursing personnel in order to identify all such reactions.
 12. To maintain and evaluate blood use statistics in order to determine blood wastage and recommend or take appropriate action.
 13. To encourage strongly the increased use of the type and screen procedure over crossmatch procedure.
 14. To evaluate physician and procedure profiles to identify patterns of isolated instances of blood use that require more in depth evaluation or obvious corrective action.
- C. Meetings : The Committee shall meet at least quarterly, or more often if deemed necessary by the Chairperson, maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Staff Executive Committee.

SECTION 6 - INFECTION CONTROL COMMITTEE

- A. Composition: The Committee shall consist of at least four (4) members of the Medical Staff, a Pathologist, and representatives from Administration and Nursing Services.
- B. Duties: The Committee shall be responsible for the surveillance of inadvertent infection potentials, the review and analysis of actual

infections, the promotion of preventive and corrective programs designed to minimize infection hazards, and the supervision of infection and environmental sanitation control in all phases of the hospital's activities. Specifically, the Committee's duties shall be:

1. To develop written standards for Hospital sanitation and medical asepsis to include a definition of infection for the purpose of surveillance, as well as specific indications of the need for an the procedures to be used in isolation. Copies of the standards shall be made readily available to all appropriate personnel.
 2. To develop, evaluate and revise on a continuing basis the procedures and techniques for meeting established sanitation and asepsis standards to include the routine evaluation of materials used in the hospital's sanitation program; namely, dietary and food handling, disposal of biological wastes, traffic control and visiting hours in all areas, sources of pollution and routine periodic culturing of autoclaves and gas sterilizers. The review of existing practices shall also include procedures for the education and orientation of personnel in the practice of aseptic techniques. The evaluation may be based upon data supplied from reputable sources or upon in-use tests performed within the hospital.
 3. To develop a practical system for reporting, evaluating and recording infections among patients and personnel in order to provide an indication of endemic situation.
 4. To assist in developing the hospital's employee health program.
 5. The Chairperson of this Committee shall have authority temporarily to institute appropriate control measures or studies when there is reasonably considered to be an immediate danger to any patient or personnel.
- B. Meetings: The Committee shall meet at least quarterly or more often if deemed necessary by the Chairperson, and review data obtained since the previous meeting. Such a review shall include: reports of Hospital-associated infections including identification of patients requiring isolation; reports of tests conducted on sterilization devices; and reports of bacteriological studies of personnel, patients and the environment. An accurate record and minutes shall be kept of

the Committee's proceedings and actions and a report of its findings and recommendations shall be made to the Medical Staff Executive Committee and the Chief Executive Officer.

SECTION 7 - RADIATION SAFETY COMMITTEE

- A. Composition: The Committee shall consist of one (1) Radiologist, experienced in the safe handling of radioisotopes, in the measurement of radio-activity and in determining radioisotope dosage for various patients' studies or treatments and at least one Cardiologist and assigned hospital personnel.
- B. Duties: The duties of the Committee shall be:
1. To review all proposals for diagnostic and therapeutic use of radionuclides.
 2. To recommend to the Medical Staff practitioners who have suitable training and experience to perform nuclear medicine procedures.
 3. To develop regulations as to the use, removal, handling and storage of radioactive materials used in nuclear medicine procedures and to recommend remedial action when there is failure to observe such regulations.
 4. Overall monitoring of radiation safety in the hospital.
- C. Meetings: The Committee shall meet at least quarterly, or more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions, and report its findings and recommendations to the Medical Staff Executive Committee.

SECTION 8 - EMERGENCY CARE COMMITTEE

- A. Composition: The Committee shall consist of one (1) representative from each clinical department, the chief of the Emergency Department, two (2) medical staff representatives-at-large, Chief Executive Officer and other health professionals.
- B. Duties: The duties of the Committee shall be:

1. To guide and coordinate all interdisciplinary activities concerning delivery of medical care in the Emergency Department.
 2. To act as a liaison between the Medical Staff and the Emergency Room practitioners in developing policy in areas of mutual concern.
 3. To formulate, recommend and maintain a viable system that will provide total "on-call" coverage of the Emergency Room by each of the various services of the Medical Staff.
- C. Meetings: The Committee shall meet at least quarterly or more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Staff Executive Committee.

SECTION 9 - BYLAWS COMMITTEE

The Bylaws Committee shall consist of five (5) members of the Active Medical Staff as appointed by the Chief of Staff. Members shall serve a three (3) year term. Members may be appointed initially for terms less than three (3) years to allow for membership continuity. The Committee shall meet as needed and shall maintain a permanent record of its proceedings and actions.

SECTION 10 - CRITICAL CARE (ICU/CCU) COMMITTEE

- A. Composition: The Committee may consist of at least one Cardiologist, one Pulmonologist, one Anesthesiologist, one Neurologist and up to five (5) additional members of the Department of Medicine and Surgery. Ex-officio members shall be the Critical Care Unit Nurse Manager, the Director of Nursing or designee, and an Administrative representative..
- B. Duties: The duties of the Committee shall be:
1. To evaluate and maintain quality patient care in the Critical Care Unit; to see that safety standards are maintained; and to see that training and education of nursing staff and practitioners are maintained on a continuing basis.
 2. To seek ways and means for improving the professional

standards and functions of these services for better patient care and proficiency in the execution of detailed responsibilities.

3. To be responsible for formulating and assuring compliance with the established rules and regulations of the Critical Care Unit and for the maintenance of the highest professional conduct of the medical staff using these facilities.
 4. To receive and consider all recommendations made by members of the Medical Staff for improving the efficiency of these units.
- C. Meetings: The Committee shall meet at least quarterly or more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Staff Executive Committee.

SECTION 11 - CONTINUING MEDICAL EDUCATION COMMITTEE

- A. Composition: The committee shall be composed of three (3) physician members, an Administrative representative and the Director of Medical Staff Education.
- B. Duties: The duties of the Committee shall be to:
1. Plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff.
 2. Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner based on the type and nature of care offered by the hospital (ie patient population served, types of services, the hospital's mission).
 3. Establish liaison with the quality assurance program in order to be apprised of problem areas in patient care and the findings of performance improvement activities, which may be addressed by a specific continuing medical education activity.
 4. Make recommendations to the Medical Staff Executive Committee regarding library needs of the medical staff.
 5. Advise administration of the financial needs of the continuing medical education program.

- C. Meetings: The Committee shall meet at least quarterly or more often if deemed necessary by the Chairperson; maintain a permanent record of its proceedings and actions and report its findings and recommendations to the Medical Staff Executive Committee.

SECTION 12 - JOINT CONFERENCE COMMITTEE

Whenever the Governing Body's decision is contrary to or notwithstanding a recommendation of the Medical Staff Executive Committee, the Governing Body shall submit the matter for recommendation to a Joint Conference Committee consisting of three (3) members each from the Governing Body and the Medical Staff Executive Committee (such members shall be appointed by their respective chairperson) within fifteen (15) days of such decision. The Joint Conference Committee shall make its recommendation to the Governing Body within fifteen (15) days after receiving the matter. The Governing Body shall consider such conference recommendation before making its final decision.

SECTION 13 - PHYSICIAN HEALTH COMMITTEE

- A. Composition: In order to improve the quality of care and promote the competence of the medical staff, the medical executive committee shall establish a physician health committee comprised of no less than three (3) active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the medical executive committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.
- B. Duties: The physician health committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, members of the medical staff or other

persons within the hospital, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the Medical Staff Executive Committee, develop educational programs or related activities.

- C. Meetings: The committee shall meet as often as necessary. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Staff Executive Committee. All information reviewed by the committee, including any report(s) to the Medical Staff Executive Committee, shall be confidential.

SECTION 14 - OTHER COMMITTEES

The Chief of Staff shall appoint special, Ad Hoc or Standing Committees as the need may arise. These committees may include, but are not limited to, Medical Staff Bylaws Committee, special care committees, and other quality assurance committees not provided for in these Bylaws or in other policies and procedures. Composition of these committees shall be determined by the complexity of the services provided. These committees shall meet not less than quarterly with minutes of each committee submitted to the Medical Staff Executive Committee.

ARTICLE XIV

IMMUNITY FROM LIABILITY

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

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

Second, that such privilege shall extend to members of the Hospital's Medical Staff and of its Governing Body, its other practitioners, its Chief Executive Officer and hospital staff or representatives, and to third parties, who supply information in good faith and without notice to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or the Medical Staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in good faith and without notice in connection with this or any other health care institution's activities related, but not limited to:

1. Applications for appointment, clinical privileges or specified services;
2. Periodic reappraisals for reappointment, clinical privileges or specified services;
3. Disciplinary action, including any statutory reporting

requirement.

4. Hearings and appellate reviews;
5. Utilization reviews; and
6. Other Hospital Department, Section, or Committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

Fifth, that each applicant or practitioner shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

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

Seventh, that each applicant to the Medical Staff, each practitioner and each person subject to approval and review under these Bylaws consents to such privileges and immunity under the terms and conditions described in this Article and these Bylaws.

Eighth, that the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to an applicant's or practitioners professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly affect patient care.

ARTICLE XV

RULES AND REGULATIONS

The Medical Staff shall initiate and 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 and guidelines pertaining to Medical Staff activities, as well as embody the level of practice that is to be required of each practitioner in the Hospital.

Such Rules and Regulations shall be a part of these Bylaws, except that each Department may adopt such Rules and Regulations as may be necessary for the proper conduct of its intra-departmental functions provided that they are not at variance with the Bylaws and Rules and Regulations of the Medical Staff. The Department Rules and Regulations shall be appended to the general Rules and Regulations. The method of adoption or amending Department Rules and Regulations shall be at the discretion of the individual Department, but such Rules and Regulations shall be subject to approval by the Medical Staff Executive Committee, and also by the Governing Body.

When significant changes are made to the Rules and Regulations, members of the Staff and individuals with clinical privileges shall be provided with revised texts of the written changes.

Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

ARTICLE XVI

HOSPITAL - MEDICAL STAFF CONTRACTUAL ENGAGEMENTS

In order to promote and maintain quality care, lower costs and administrative efficiency, hospital-based services may be provided through physician contracts with the Hospital. Such agreement (s) may provide for the extent of such services.

The Medical Staff shall review and make recommendations to the Administration regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decisions being made, in the following situations:

- the decision to execute an exclusive contract in a previously open department or service;
- the decision to renew or modify an exclusive contract in a particular department or service;
- the decision to terminate an exclusive contract in a particular department or service.

Individuals in administrative positions who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

ARTICLE XVII

PATIENT ADMISSION

Every patient must be admitted by a member of the Medical Staff in good standing and remain under the primary medical care of a member in good standing of the Medical Staff with the appropriate privileges.

ARTICLE XVIII

ADOPTION AND AMENDMENT OF BYLAWS

- A. Upon the request of the Chief of Staff, the Medical Staff Executive Committee, the Bylaws Committee, or upon timely written petition signed by at least 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. Such action shall be taken at a regular or special meeting provided written notice of the meeting is sent to all members of the Medical Staff at least 30 days prior to such meeting. Such notice shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).
- B. A minimum of 25% of the voting members of the Medical Staff must be present for the purpose of enacting a Bylaw change. The change shall require an affirmative vote of 51% of the members voting in person or by written ballot.
- C. Bylaw changes adopted by the Medical Staff shall become effective following approval by the Governing Body. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.
- D. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.
- E. Members of the Staff and other individuals with clinical privileges shall promptly be presented with copies of the revised text of any Bylaws changes.

ARTICLE XIX

BYLAWS REVIEW

The Bylaws will be reviewed every three years for needed revision by the Medical Staff officers in conjunction with members of Administration and the Governing Body.

ARTICLE XX

DEFINITIONS

SECTION 1 – DEFINITIONS

- A. The term "Clinical Privileges" or "Privileges" means the permission granted to Medical Staff Members and Allied Health Professional Affiliates to admit patients and/or provide patient care services, and includes unrestricted access to these Hospital resources, including equipment, facilities, and Hospital personnel, which are necessary to effectively exercise those privileges.
- B. The term "Medical Staff Executive Committee" means the Medical Staff Executive Committee of the Medical Staff unless specific reference is made to the Medical Staff Executive Committee of the Governing Body.
- C. The term "Chief Executive Officer" means the individual appointed by the Corporation to provide the overall management of the Hospital.
- D. The term "Ex-Officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
- E. The term "Governing Body" means the Board of Trustees of the Hospital.
- F. The term "Allied Health Professional" or "Affiliate" means an individual, other than a Practitioner, whose patient care activities require him/her to exercise independent judgment within the areas of professional competence and to perform specified patient care services and who is qualified to render direct or indirect medical or surgical care under the supervision of a medical staff member with appropriate privileges. Health Professional Affiliate shall include, without limitation, clinical psychologists, nurse clinicians/practitioners, physician assistants, and anesthetists. Affiliates may be independent practitioners or employees of either the Hospital or members of the Medical Staff.

Prior to the provision of care, treatment or services, the qualifications and competence of a non-employee individual brought into the organization by a licensed independent practitioner to

provide care, treatment or services are evaluated and determined to be commensurate with the qualifications and competence that would be required if the individual were to be employed by the organization.

The organization reviews the qualifications, performance and competence of each non-employee individual brought into the organization by a licensed independent practitioner to provide care, treatment or services, at the same periodic time frame identified by the organization for individuals employed by the organization.

- G. The term "Hospital" means Stringfellow Memorial Hospital.
- H. The term "Limited Health Practitioner" shall mean those practitioners whose scope of practice is anatomically limited by licensure law, except for oral surgeons.
- I. The term "Medical Staff" or "Staff" means the group of physicians, and practitioners duly licensed to practice medicine and surgery in the State of Alabama who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
- J. "Medical Staff Year" means the period from October 1st through September 30th.
- K. The term "Member" means a physician, dentist or podiatrist who has been granted membership on the Medical Staff, and granted clinical privileges in accordance with these Bylaws.
- L. The term "on call" shall mean the practitioner's ability to respond in person to the Hospital within thirty (30) minutes of call by the Hospital.
- M. The term "Oral Surgeon" shall mean a duly licensed dentist who has successfully completed an approved oral surgery residency program.
- N. The term "Physician" shall mean a medical or osteopathic doctor who is duly licensed in the State of Alabama to practice medicine.
- O. The term "Practitioner" means a duly licensed dentist, podiatrist, or medical or osteopathic physician.