MEDICAL STAFF BYLAWS OF GENESIS MEDICAL CENTER, **DAVENPORT CAMPUS**:

Governance and Organization Manual

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Accredited by The Joint Commission

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Preamble

Genesis Medical Center, Davenport Campus (the "Hospital") is a hospital organized under the laws of the State of Iowa. The Hospital's purpose among others is to furnish and supply hospital facilities and public health services, including patient care, education and research, to the community.

The Medical Staff recognizes that it is delegated the responsibility for overseeing the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the Medical Staff process, subject to the ultimate authority of the Governing Board of the Hospital.

It is further recognized that the cooperative efforts of the Medical Staff, Hospital Administration and the Governing Board are necessary to fulfill the Hospital's purpose and best interests of its patients. The members of the Medical Staff organize themselves and shall act and function in accordance with these Bylaws.

The Governing Board is the policy-making body responsible for the overall operation of the Hospital. The Administration of the Hospital is the arm through which the Governing Board functions on a day-to-day basis and provides the mechanism and communication vehicle to affect these purposes.

Appointment to the Medical Staff shall confer upon the member permission to exercise only those clinical privileges that are specifically granted by the Governing Board in accordance with these Bylaws. No practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been granted clinical privileges. Medical Staff members and Advanced Practice Professionals/Allied Health Professionals with clinical privileges are neither employees nor independent contractors of the Hospital, unless they have separately established such a relationship with the Hospital.

Membership on the Medical Staff is a privilege which shall be extended only to those physicians, oral surgeons, and podiatrists who have demonstrated professional competence and meet and continue to meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and as may be established by the Medical Staff and Governing Board. Every patient admitted to the Hospital must be under the care of a member of the Medical Staff or appropriately privileged APP/AHP. A doctor of medicine (MD) or osteopathy (DO) shall be responsible for the care of each patient with respect to any medical or psychiatric condition that is not within the scope of practice and clinical privileges of a non-MD/DO. The Hospital and Medical Staff shall not discriminate on the basis of race, national origin, religion, color, creed, sex, handicap, age or other legally protected status.

ARTICLE I

MEDICAL STAFF

1.1. Establishment of Medical Staff. The Medical Staff consists of all physicians and other practitioners who have been granted membership according to the qualifications and procedures set forth in these Medical Staff Bylaws. Membership provides the member with the ability to participate in Medical Staff committees, meetings and other matters more fully described in these Bylaws. Membership on the Medical Staff is distinct from the right to exercise clinical privileges.

The Medical Staff recognizes that the Governing Board has, in the exercise of its discretion, delegated to the Medical Staff the responsibility for providing appropriate professional care to Hospital's patients. The Medical Staff shall conduct a continuing review and appraisal of professional care rendered in the Hospital and shall report such activities and its results to the Governing Board. The exercise of clinical privileges by all practitioners within the Hospital shall be subject to these Bylaws, rules and regulations and applicable Medical Staff and Hospital policies, procedures, and directives.

1.2. Ultimate Authority of the Governing Board. The Medical Staff recognizes that the Governing Board has full power and authority to do all things deemed necessary and expedient in the governance, management, and business and affairs of the Hospital. All Medical Staff members and APP/AHPs are subject to appointment, termination or modification of their Medical Staff membership and/or clinical privileges by the Governing Board.

1.3. Medical Staff Adoption of Credentialing Manual. As a related manual of the Bylaws, and following recommendation by the Medical Staff, the Governing Board will adopt and implement a Credentialing Manual that sets forth the Medical Staff and APP/AHP qualifications, criteria, and procedures governing: 1) appointments and reappointments to the Medical Staff; 2) delineation of clinical privileges for both the physician and APP/AHP; and 3) assignments to Medical Staff and APP/AHPs. These qualifications and criteria include, but are not limited to the medical education, training, experience, competence, judgment, character, licensure, certification and professional conduct of each applicant, member and APP/AHP.

1.4. Medical Staff Adoption of Corrective Action and Fair Hearing Plan. As a related manual of the Bylaws and following recommendation by the Medical Staff, the Governing Board will adopt and implement a Corrective Action and Fair Hearing Plan for the Medical Staff setting forth: 1) those procedures relating to corrective actions involving members of the Medical Staff; 2) the fair hearing and appellate review rights which will be afforded to Medical Staff applicants and members of the Medical Staff in the event of a reduction, restriction, suspension, revocation, denial or failure to renew Medical Staff membership or clinical privileges as part of a professional review action or adverse action; 3) the circumstances under which such hearing rights will be made available; 4) the process under which such hearing and appellate reviews will be

conducted; and 5) the method of selecting members of the hearing and appellate review committees.

1.5. Medical Staff Adoption of Rules and Regulations. The Medical Staff shall adopt such Rules and Regulations as may be necessary to more specifically implement the general principles found within the Bylaws; to promote the delivery of quality health care within the Hospital; and to provide for the efficient operation of the Hospital. In the event of any inconsistency between these Bylaws and the Rules and Regulations or Medical Staff polices, the Bylaws will govern.

1.6. Medical Staff Adoption of Policies. The MEC is delegated the authority to develop and adopt those policies that are necessary to more specifically implement the general principles found within these Medical Staff Bylaws and Rules and Regulations. In the event of any inconsistency between these Bylaws and any Policy, these Bylaws shall govern.

1.7. Minimum Qualifications. Only those practitioners who can continuously demonstrate or provide evidence of the following qualifications to the satisfaction of the MEC and Governing Board will be eligible for appointment or reappointment to the Medical Staff and/or the granting of clinical privileges:

a. Current and valid, non-probationary and unlimited Iowa license applicable to his/her profession.

b. For physicians, oral surgeons and podiatrists, board certification as set forth below:

i) Current certification by a board approved by the American Board of Medical Specialists, the American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, American Dental Association or the American Board of Podiatric Surgery, as applicable to the practitioner's specialty and requested privileges; or

ii) If not certified, having completed the formal training requirements leading to certification and be eligible for certification by the American Board of Medical Specialists, the American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, or any other specialty board approved by the MEC and Governing Board. Each practitioner must receive certification within the lesser of the period of time set forth by the applicable Specialty Board or as required by the practitioner's primary Department. A failure to achieve such certification with the specified time period shall result in automatic non-renewal of privileges, unless the MEC makes a recommendation for a two year extension for the purpose

of obtaining a certification and such extension is approved by the Governing Board; or

iii) In exceptional circumstances the Governing Board may accept alternative information to the board certification requirement upon recommendation by the MEC, if the practitioner demonstrates to the MEC and the Governing Board the equivalent training, education, experience, ability to perform the clinical privileges requested, and outstanding reputation, which may be evidenced by faculty appointment status, CME accreditation activities, and other activities. The MEC and Governing Board may take into consideration those circumstances where an applicant is a member of the medical staff or an applicant at another hospital or facility affiliated with Genesis Health System. The MEC shall document the exceptional circumstances supporting any such recommendation and forward such documentation with its recommendation. A decision to accept alternative information in exceptional circumstances shall not be considered a waiver of criteria for Medical Staff membership or clinical privileges.

iv) Physicians, oral surgeons and podiatrists who were appointed to the Medical Staff as of June 1, 1994 and who are not board certified shall not be required to become board certified as a condition of continued Medical Staff membership and clinical privileges, provided they otherwise meet the established competency requirements and other relevant criteria as established by the Medical Staff and Governing Board.

c. Good reputation and an ability to work with others. Factors bearing on reputation include, but are not limited to, whether the member has engaged in illegal acts or acts of moral turpitude or whether applicant or member's reputation reflects poorly on the Hospital.

d. A physical and mental health status which would not adversely affect clinical performance.

e. Sufficient proof of professional liability insurance with liability limits of at least $1,000,000 per claim / $3,000,000 in the aggregate which covers liability occurring in the exercise of delineated clinical privileges and held with a company authorized to conduct business in Iowa.

f. Practitioners are required to arrange their practice and living arrangements in a manner which assures timely response to the Hospital in accordance with Departmental standards of practice and relevant state law.

g. Is not under current sanction by the Office of Inspector General of the Department of Health and Human Services or currently excluded or barred from federal or state health care programs.

h. Demonstrated competence in all aspects of electronic health record, as required by Hospital or Medical Staff policies.

i. Eligible to participate in federal and Iowa governmental health care programs, including Medicare and Medicaid.

j. Acceptable character, competence, training, experience, background, and judgment for all clinical privileges requested.

k. Appropriate written and verbal communication skills.

l. Willingness and ability to properly discharge the responsibilities established by the Governing Board, Medical Staff and Hospital.

1.8. Responsibilities. As initial and ongoing conditions for appointment and reappointment to the Medical Staff and/or clinical privileges, each practitioner shall:

a. Provide patients with professional care of generally recognized quality and efficiency;

b. Abide by the Bylaws, Procedures, Rules, Regulations and policies of the Medical Staff and the Hospital;

c. Prepare and complete accurate and timely medical and other required records for all patients for whom practitioner without Collaborative Agreement provides care;

d. Abide by the ethics of their profession and Ethical and Religious Directives for Health Care Services;

e. Comply with the Hospital's communicable disease surveillance program pursuant to the Hospital and MEC-endorsed policy;

f. Submit to and meaningfully participate in focused and ongoing or periodic peer review of professional competence and skill and related quality assurance and improvement activities and policies, whether undertaken internally or externally;

g. Comply with the Hospital's Emergency Department and Ambulatory Care call coverage policy(ies) as established by the Chairperson(s) of the respective Department(s), MEC and Hospital, and consistent with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and current Hospital policy. The obligation to comply with

established call coverage policies applies regardless of assigned Medical Staff category;

h. Successfully complete in a timely manner any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination and submit required program documentation. Applicants and members shall comply with all rules and regulations and other applicable policies of the Medical Staff and Hospital related to such training programs or EMR systems;

i. Comply with any policy and budget adopted by the MEC related to Medical Staff dues and application fees; and

j. Report to the President of the Medical Staff, Administrator, and/or VPMA/CMO, within five (5) business days of receiving notice of any of the following:

i. The initiation of any challenge or investigation by the Medical Licensing Board or other governmental agency of any professional license or certification and the scope and nature of any charges related to the challenge or investigation;

ii. The initiation of any investigation by the Office of the Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS) or any other state or federal agency, including the scope and nature of any charges relating to the investigation, including any change in eligibility with third-party payers or participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the OIG or CMS, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

iii. The initiation of any challenge or investigation by the DEA or the voluntary or involuntary relinquishment of any state controlled substance license or DEA registration;

iv. The voluntary or involuntary termination of medical staff membership or clinical privileges at another hospital or ambulatory surgery center;

v. The voluntary or involuntary limitation, reduction or loss of medical staff membership or clinical privileges at another hospital or ambulatory surgery center;

vi. The practitioner's involvement in a professional liability action, including the parties thereto and related allegations;

vii. The investigation, arrest, indictment or conviction with regard to any felony or criminal misdemeanor; or

viii. The suspension, reservation of rights, termination of professional liability insurance at the scope, level or amount as determined by the Governing Board.

ARTICLE II

MEDICAL STAFF CATEGORIES

The Medical Staff shall consist of the following categories, all of whom must continuously meet the basic qualifications and responsibilities set forth in Sections 1.7 and 1.8 of these Bylaws and such other qualifications that are specific to each category. Based on the qualifications for each category, practitioners may be administratively reclassified to the category for which they are eligible should the practitioner's status or eligibility change during an appointment period, including exceeding or failing to meet the maximum/minimum patient contacts for a given category.

2.1. Active Staff. The Active Staff shall consist of those physicians, oral surgeons, and podiatrists performing more than twenty (20) patient contacts over a two (2) year period at the Hospital and assume all the functions and responsibilities of membership, including attendance of patients pursuant to the emergency patient call schedule approved by the Hospital. Members of the Active Staff are:

a. Appointed to a specific Department;

b. Permitted to exercise clinical privileges as granted by the Governing Board, unless otherwise provided;

c. Eligible to vote on all Medical Staff matters;

d. Eligible to hold Office; and

e. Eligible to serve on Medical Staff Committees.

The Medical Staff recognizes the benefit of having rheumatologists, dermatologists and allergists on the Medical Staff, and that these specialties are rarely needed for emergency patient call obligations. Therefore, these specialties can be members of the Active Staff without having designated emergency call obligations and without meeting the minimum patient contacts requirement, unless otherwise required by their Department.

Unless otherwise specified, a "patient contact" for purposes of these Bylaws means a face-to-face practitioner to patient encounter from which it is possible to make a meaningful evaluation of the member's clinical experience, competence, and care of the

patient. A patient contact includes those activities commensurate with the scope of clinical privileges held by the member for those patient contacts that do not involve practitioner-to-patient encounters, including collaborative care, pathology and radiology-related contacts, but excludes those activities that are solely academic teaching-related. All patient contacts for purposes of fulfilling any patient contacts requirement must occur at the Hospital, unless by electronic medical record entry/access, telemedicine link or an off-site laboratory procedure. To ensure this patient contact requirement represents an adequate measure of a given member's clinical competency or Medical Staff involvement, no patient admission, patient care activity or Medical Staff activity will result in more than one (1) patient contact for any single practitioner. Upon request and presentation of sufficient information, the MEC and Governing Board reserve the right in their discretion to accept appropriate documentation of patient care activities occurring at another facility for purposes of meeting a patient contact requirement.

2.2. Courtesy Staff. The Courtesy Staff shall consist of practitioners who are eligible for Medical Staff membership, but who attend or admit to the Hospital not more than twenty (20) patients over a two (2) year period. In order to maintain Courtesy Staff status, Courtesy Staff members must document their admission or involvement in the care or treatment in the Hospital for at least five (5) patients during their appointment period. Members of the Courtesy Staff are:

a. Appointed to a specific Department;

b. Permitted to exercise clinical privileges as granted by the Governing Board, unless otherwise provided;

c. Eligible to serve and vote on Medical Staff Committees;

d. Eligible to attend and participate in Medical Staff meetings, educational sessions and other functions; and

e. Ineligible to hold Office or vote at Department or on Medical Staff matters other than at the Committee level.

2.3. Covering Staff. This category is intended for practitioners who are Active or Courtesy members at another Genesis Health System hospital who are covering call for a member of their physician group or practice. Unless required by applicable Department privileging criteria, Covering Staff do not have a minimum activity threshold. Covering Staff shall execute all documents necessary for the Hospital to obtain information necessary to assess competence from the practitioner's primary hospital. Covering Staff shall consist of physicians, oral surgeons, and podiatrists who:

a. Desire membership on the Medical Staff and clinical privileges solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice;

b. Hold Active or Courtesy membership/clinical privileges at a Genesis Health System hospital;

c. Are exempt from patient contact requirements;

d. At each reappointment period, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges including, but not limited to, information from another facility or from the individual's Office practice.

Covering Staff members are:

a. Permitted to exercise clinical privileges as granted by the Governing Board, unless otherwise provided;

b. Eligible to attend Medical Staff educational meetings and other functions; and

c. Ineligible to hold Office, serve on Committees or vote on Department or Medical Staff matters.

2.4. Affiliate Staff. This category is designated for those practitioners who are seeking Medical Staff membership without clinical privileges, residents who exclusively provide house staff/moonlighting coverage under contract with the Hospital or whose practice at the Hospital will or does occur from a remote location, such as through a telemedicine link or similar form. Residents who will provide house staff/moonlighting coverage under contract with the Hospital are not required to fulfill the board certification requirement of Section 1.7 above. Affiliate Staff members are:

a. Permitted to exercise clinical privileges as granted by the Governing Board in the case of residents who exclusively provide special care unit or house staff/moonlighting coverage under contract with the Hospital. Affiliate Staff are not eligible for admitting privileges;

b. Eligible to serve and vote on Medical Staff Committees;

c. Eligible to attend and participate in Medical Staff meetings, educational sessions and other functions; and

d. Ineligible to hold Office or vote at Department or on Medical Staff matters other than at the Committee level.

Affiliate Staff who desire assignment to another Staff category must apply for clinical privileges and meet all requirements set forth in the Bylaws and as required by the applicable Department.

2.5. Emeritus Staff. This category consists of those practitioners who are no longer active in the Hospital and who are honored by emeritus positions. They may have retired from an active hospital practice or are of outstanding reputation who are not necessarily residents in the community. They must have held a medical license in good standing, however,

they need not have a current license to practice. Emeritus Staff members are not eligible for clinical privileges and may not vote or hold Office.

2.6. **Temporary Staff**. This category is designated for those practitioners who are seeking membership on the Medical Staff and/or clinical privileges for a time-limited or temporary duration as more fully described below.

2.6.1 Temporary Clinical Privileges. Temporary clinical privileges may be granted for a limited period of time while new applicants are awaiting review and approval of a pending application or to meet an important patient care need as more fully described in Section 4.7 of the Credentialing Manual.

2.6.2 Termination of Temporary Privileges. With the concurrence of the appropriate Department Chairperson and the President of the Medical Staff, the Administrator may modify or terminate a practitioner's temporary clinical privileges at any time. Any refusal to grant temporary clinical privileges or modification or termination of temporary privileges shall not entitle the practitioner to separate rights of hearing and appellate review as set forth in Medical Staff Corrective Action and Fair Hearing Plan.

2.7. **Disaster Staff.** In the event of a disaster or state declared emergency, practitioners may be granted clinical privileges pursuant to a Governing Board-approved Disaster Privileges policy. Disaster privileges terminate immediately once the emergency management plan is no longer active.

2.8. **Request for Change in Category.** All practitioner requests for a change in Medical Staff category will be made in writing, to the MEC. The MEC shall consider the practitioner's request, at its next regularly scheduled meeting. The MEC shall forward its recommendation to the Governing Board, to consider at its next regularly scheduled meeting for final consideration. The Board's decision will denote the effective date of any requested category change. If approved, all voluntary requests for a change in category must remain in effect for one (1) year before subsequent requests will be considered.

ARTICLE III

CLINICAL PRIVILEGES

3.1. **Criteria for Granting Clinical Privileges.** Clinical privileges shall be delineated, hospital-specific and based upon verified information regarding the individual's licensure, training, character, judgment, experience, health status and current clinical competence, as evaluated by the appropriate Department Chairperson, the Credentials Committee, and the MEC. All clinical privileges are subject to approval by the Governing Board. The MEC shall consider the recommendations of the Credentials Committee regarding each application for appointment and reappointment and each request for modification of membership status or clinical privileges in accordance with the process defined in the Credentialing Manual, and shall transmit the MEC recommendation to the Governing Board.

3.2. Procedure for Granting Clinical Privileges. The procedures for granting membership and/or clinical privileges are set forth in the Credentialing Manual. Each Department shall develop clinical privilege delineations which define the scope of each level of practice and the standards to be met by the practitioner.

3.3. Medical History and Physical Exam. Within the scope of their clinical privileges, all practitioners are responsible for completing and documenting in the medical record an accurate and complete physical examination, including a health history.

Practitioners granted clinical privileges to perform history and physical examinations must complete and document the results of the history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services.

When a history and physical examination is completed within thirty (30) days prior to admission or registration, a re-examination of the patient must be performed and any updates to the patient's conditions must be documented in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Additional requirements for the completion of history and physical examinations may be set forth in the Medical Staff Rules and Regulations and/or applicable Medical Staff polices.

3.4. FPPE/OPPE. All practitioners with clinical privileges will undergo Focused Professional Practice Evaluation at the time clinical privileges are granted. Practitioners shall also undergo Ongoing Professional Practice Evaluation throughout their clinical privileges term, as defined in Medical Staff policies with the results of such evaluation activities being utilized during reappointment and renewal of clinical privileges.

3.5. Closing of Departments/Exclusive Contracts. If the Hospital exercises its option to enter into an exclusive contract with a practitioner or a practitioner group to provide services at the Hospital and the exclusive contract results in the total or partial termination or reduction of Medical Staff membership or clinical privileges of a current Medical Staff member or to close membership in particular departments within the Hospital to new applicants, each affected Medical Staff member(s) shall receive sixty (60) days prior notice as to the effect will have on his/her Medical Staff membership or clinical privileges.

The Governing Board will consult with the Medical Staff prior to closing membership in the Medical Staff, any portion of the Medical Staff or a Department over the objections of the Medical Staff. The Governing Board will provide the Medical Staff a detailed written explanation for the decision sixty (60) days prior to the effective date of any such closure.

A Medical Staff member whose clinical privileges have been so affected may request an administrative hearing according to procedures and standards set forth in the Corrective Action and Fair Hearing Plan.

ARTICLE IV

OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be a President, President-Elect and Secretary-Treasurer.

4.1. Qualifications of Officers. All Officers must be members of the Active Staff at the time of their nomination and election and remain Active Staff members in good standing during their term of Office and subsequent advancements. All individuals nominated for Office should have a reputation for leadership and excellent patient care services, and be willing to serve in best interests of the Hospital.

4.2. Election of Officers.

a. The Offices of President-Elect and Secretary/Treasurer shall be elected at an annual meeting of the Medical Staff. Only members of the Active Staff shall be eligible to vote.

b. The Nominating Committee shall consist of three Active members: one (1) member appointed by the President-Elect of the Medical Staff and two (2) members appointed by the MEC. This Committee shall offer one or more nominees for each Office being elected. Nominees should have a reputation for leadership and excellent patient care services, and agree to accept the nomination. Failure to maintain such status shall immediately result in the member's disqualification to hold Office.

c. Nominations may also be made from the Active Staff up to forty-five (45) days before the annual meeting of the Medical Staff. Nominations from the Active Staff must be made by petitions signed by at least ten (10) members of the Active Staff and filed with the Secretary-Treasurer at least thirty (30) days prior to the annual meeting. For all nominations made by petition, the nominee must meet all applicable eligibility requirements, and the nominee must be willing to accept the nomination. Immediately after the filing of such a petition, the names of eligible additional nominees shall be reported to the Medical Staff by posting the names of these nominees in an appropriate location in the Hospital.

d. Officers shall be elected by a majority vote of the quorum at the annual meeting. A quorum for the meeting shall be those Active Staff members present, either in person or represented by duly executed written absentee ballots that are received prior to the annual meeting. Proxy voting is not permitted. Only Active Staff members who are in good standing as defined by these Bylaws are eligible to vote.

4.3. Term of Office. The terms of Office for President, President-Elect, Secretary-Treasurer shall be for a period of two (2) calendar years with no consecutive terms. Following his/her term, the President-Elect shall automatically succeed to the Office of President.

All terms except those filled by appointment shall commence on January 1 following election at the annual meeting.

4.4. Vacancies in Office. Vacancies in Office during the Medical Staff year, except for that of President, shall be temporarily filled by the MEC until the next annual election, at which time an election will be held. If there is a vacancy in the Office of President, the President-Elect shall serve out the remaining term and continue as President through the next election.

4.5. Termination/Removal of Officers. An Officer of the Medical Staff may be removed for failing to carry out the duties of the Office, failing to meet the qualifications to remain on the Medical Staff or any other conduct which is deemed by a majority vote of the Medical Staff to render the Officer unfit for the position. Upon receipt of a petition seeking recall of an Officer of the Medical Staff and provided the petition has been signed by not fewer than one-third (1/3) of the Active Staff, the Secretary-Treasurer shall call a special meeting to be held within thirty (30) days of receipt of the petition. If a majority of the Active Staff, present in person or by duly executed written absentee ballot, vote for recall, the Office shall be declared vacant. Any Office vacated by recall shall be filled according to the procedure outlined in Section 4.4 of this Article.

4.6. Duties of Officers

4.6.1 President. The President shall have responsibility to:

a. Act in coordination and cooperation with the Administrator of the Hospital in all matters of mutual concern within the Hospital;

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

c. Be Chairperson of the MEC;

d. Represent the MEC to the Governing Board or its committees, in positions designated by Governing Board.

e. Serve as ex-officio member of all other Medical Staff committees without privileges to vote;

f. In conjunction with the MEC, be responsible for (1) the enforcement of the Medical Staff Bylaws, Rules and Regulations and policies, (2) implementing sanctions where indicated, and (3) ensuring compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

g. Represent the views, policies, needs and grievances of the Medical Staff to the Hospital and the Administrator;

h. Assure accurate and complete minutes of all Medical Staff meetings; and

i. Call Medical Staff meetings.

4.6.2 President-Elect. In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. The President-Elect shall serve as a member of the MEC of the Medical Staff. The President-Elect shall automatically succeed the President when the latter fails to serve for any reason.

4.6.3 Secretary -Treasurer. The Secretary-Treasurer shall have the following duties:

a. Be a member of the MEC;

b. Be accountable for Medical Staff finances and provide periodic reports;

c. Attend to all correspondence and perform other duties pertaining to the Office; and

d. In the absence of the President and President-Elect, assume all the duties including the authority of President.

ARTICLE V

COMMITTEES

5.1. Standing Committees. Standing Committees of the Medical Staff are organized to perform specific duties of the Medical Staff. The Committees may delegate details of committee activity to persons not necessarily engaged in medical practice but who are nevertheless fully qualified by training and experience to accomplish their assignments. Only members of the Medical Staff shall be eligible to vote on matters brought before Standing Committees. All Standing Committees shall report to the MEC. Notwithstanding the composition requirements described below, the majority of Standing Committee members must be Active Staff. The VPMA shall be an ex officio member without vote on all standing committees. The following Standing Committees are recognized:

a. Medical Executive Committee;

b. Credentials Committee;

c. Utilization Review Committee; and

d. A Committee or Committees that fulfill the functions of, pharmacy and therapeutics, quality improvement, mortality, tissue, transfusion, disaster, infection control, medical records review, medication use and continuing medical education, as more fully described in the Medical Staff Rules and Regulations.

5.1.1 Medical Executive Committee

a. Membership consists of:

i) President of the Medical Staff, who shall serve as Chairperson;

ii) President-Elect;

iii) Secretary-Treasurer;

iv) Chairpersons of all Clinical Departments; and

v) Chairperson of the Credentials Committee.

All of the above shall be voting members with the exception of the President of the Medical Staff, who shall vote only in the event of a tie. The Administrator of the Hospital, VPMA, CMO, the Director of the Family Practice Residency Program and the Medical Director of the Hospitalist Program, or their designated representatives shall be ex-officio members of this Committee, without voting privileges.

b. Duties:

i) The MEC shall be empowered to act for the Medical Staff in all matters, except those which require Medical Staff approval under these Bylaws, Hospital policies and federal or state law. The MEC will consider questions which require Medical Staff approval prior to their being brought before the voting Medical Staff.

ii) The MEC shall receive and act on reports and recommendations from Medical Staff committees, Departments, Administration and the Governing Board.

iii) The MEC shall be the principal judicial body of the Medical Staff and shall have the power to consider, recommend, and where appropriate, implement corrective action.

iv) The MEC shall formulate recommendations concerning the following matters which shall be transmitted directly to the Governing Board for its consideration:

(a) The structure of the Medical Staff;

(b) The mechanism used to review credentials and delineate privileges;

(c) The individuals eligible for Medical Staff membership;

(d) The delineated clinical privileges recommended for each eligible practitioner; and

(e) The mechanism used to conduct, evaluate, and revise quality assurance activities of the Medical Staff.

v) In accordance with Hospital policy, the MEC shall periodically review the list of clinical contractual arrangements which are for the provision of care, treatment and services provided to Hospital patients and provide comments and recommendations on the source of clinical services.

vi) Consider, adopt, and implement various policies and procedures as may be necessary to fulfill and enforce the general provisions of the Bylaws and the Medical Staff's overall obligations.

vii) Report to the Hospital on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

c. Executive Session. MEC may go into Executive Session upon the call of President to discuss those matters deemed by President as confidential or otherwise protected. Ex-officio members of MEC may attend Executive Sessions. All others shall be excused, unless invited to stay by the President of the Medical Staff.

5.1.2 Credentials Committee

a. Membership. This Committee shall be composed of six (6) members appointed by the President-Elect of the Medical Staff and shall be broadly representative of the Departments of the Medical Staff. The President-Elect shall be a non-voting ex-officio member of the Committee.

b. Terms. Committee members will serve staggered six (6) year terms which will be phased in over a number of years. Upon the expiration of terms of current members, two (2) of the positions will be for a two (2) year term and two (2) of the positions will be filled for a four (4) year term. The other two (2) positions will be appointed to six (6) year terms. Thereafter, all appointments will be for six (6) year terms, unless a new member is filling an unexpired term of a former member. An APP/AHP representative shall be appointed to serve when matters concerning APP/AHPs are under consideration.

c. Meetings. The Credentials Committee shall meet monthly and report directly to the MEC.

d. Duties:

i) The Credentials Committee shall review and make written recommendations on: all applications for Medical Staff

membership and clinical privileges; requests by Medical Staff members for new or increased clinical privileges; Medical Staff reappointments; and any other matters relating to credentials which are referred to it by a Department Chairperson, MEC or the Governing Board.

ii) The Credentials Committee shall develop the procedures and policies for processing applications and granting clinical privileges and make recommendations for their revision to the MEC.

iii) The Credentials Committee shall recommend to the MEC the level of qualification appropriate for the performance of a given procedure or other clinical privileges. This relates particularly to procedures or other privilege requests which are new or are not routinely performed in the Hospital.

5.1.3 Utilization Review Committee

a. Membership. The Committee shall consist of three (3) physician members, one of whom is a Department Chairperson, appointed by President-Elect, and other members as specified in the Utilization Plan. A physician member shall serve as co-Chairperson.

b. Meetings. The Committee shall meet monthly or as determined by the Committee.

c. Duties. The duties of the Committee shall be set forth in a Committee Charter adopted by the Committee.

d. Term. Physician members shall serve a term of three (3) years, which shall be staggered so that a new appointment is made each year. As reappointments are made for current members, the first physician position shall be for one (1) year; the second physician position shall be for two (2) years; and the third physician position shall be for three (3) years. Thereafter, reappointment shall be for three (3) years.

5.1.4 Other Standing Committees. The Medical Staff may have such other standing committees as designated by the MEC at the beginning of each MEC term. The membership, meeting schedule, and duties of each committee shall be set forth in the Rules and Regulations.

5.2. Ad Hoc Committees. Ad Hoc Committees may be formed by the President of the Medical Staff or any Department Chairperson or other committee chairperson for the purpose of studying, solving or making recommendations on any specific problem within their purview. The composition, organization and mode or procedure shall be designated by the person responsible for the committee's formation, provided however, that a majority of Ad Hoc Committee members must be Active Staff. Upon completion of its charge the Ad Hoc Committee shall be dissolved.

5.3. Use of Designees. Any Medical Staff Committee, through its Chairperson or authorized Medical Staff Officer, may delegate certain tasks and activities to various designees to assist the Committee in fulfilling its duties and responsibilities, which may include activities related to credentialing, privileging or peer review. Designees may be internal or external to the Hospital and Medical Staff, including other committees, individuals, consultants or similar Corporation resources. Designees who are not members of the Medical Staff, but who are assisting a Medical Staff committee with its functions and responsibilities, including credentialing, privileging or peer review activities, may participate in committee activities as authorized, but may not participate when related action is taken by the committee.

ARTICLE VI

MEETINGS OF THE MEDICAL STAFF

6.1. Meetings

6.1.1 Annual Meeting. The annual meeting of the Medical Staff shall be the last meeting before the end of each calendar year. Annual reports may be made and election of Officers shall, when appropriate, be accomplished at this meeting.

6.1.2 Regular Meetings. Regular meetings of the Medical Staff, Departments, and committees may be held at times, places and intervals as designated by the applicable chairperson or as otherwise specified in the Rules and Regulations. The Medical Staff will hold four (4) regular meetings each year. Attendance by Active Staff at Medical Staff meetings is strongly encouraged.

6.1.3 Special Meetings. Special meetings of the Medical Staff may be requested at any time by the Governing Board, the President, the MEC or any five (5) members of the Active Staff. The timing of the meeting shall be at the direction of the President of the Medical Staff and shall occur within fourteen (14) days of the request, unless otherwise agreed to by the requesting party(ies).

Special meetings of a Department or committee may be called by the Department or committee chairperson, the President or one-third (1/3) of the Department or committee members but not fewer than two (2) members

At least a forty-eight (48) hour notice of all special meetings and their purpose shall be given by methods customarily used by Medical Staff Affairs. No business shall be transacted at any special meeting except for the purpose stated in the notice.

6.1.4 Meeting Record. Complete and accurate minutes shall be kept by a designated recorder for all Medical Staff, Department, and committee meetings.

6.2. Quorum

6.2.1 Medical Staff. One-third (1/3) of the total members of the Active Medical Staff, either in person or by absentee ballot, shall constitute a quorum for actions of the Medical Staff, with the exception of amending the Medical Staff Bylaws or removing a Medical Staff Officer. The quorum requirement for these actions is fifty percent (50%) of the voting members of Active Staff, either present in person or represented by duly executed written absentee ballot.

6.2.2 Departments and Committees. For the Medical Executive Committee and the Credentials Committee fifty percent (50%) of the total committee members shall constitute a quorum. For all other department or committee meetings one-third (1/3) of the total membership of a Department or committee shall constitute a quorum for actions of the Department or committee, unless the Department or committee establishes a greater percentage as set forth in the Rules and Regulations or applicable Medical Staff policy.

For all matters, the quorum shall be determined at the time the meeting is called to order. Once a quorum is determined, it shall continue until the adjournment of the meeting and shall not be broken by the subsequent withdrawal of any members. Absentee ballots can only be voted for those issue(s) listed on the ballot.

6.3. Manner of Action. Except as otherwise provided by these Bylaws, an action at the Medical Staff, Department and committee level will be approved if a majority of those present and eligible at a meeting in which a quorum is present, including absentee voting when permitted, votes to support the action. For purposes of being present at Department and committee meetings, members may participate by telephonic or electronic means approved by the MEC. Department or committee action occurring by telephonic or electronic means approved by the MEC must include a voting record of all eligible members. All Medical Staff Department and committee actions and recommendations are subject to the review and approval by the MEC.

6.4. Absentee Voting. Absentee voting shall be permitted for only those matters specifically designated in these Bylaws or for such other matters as the President of Medical Staff certifies and so designates in the notice of the special or regular meeting at which the matter will be addressed. The President of Medical Staff may designate the form of absentee ballot to be submitted on any matter. All absentee ballots shall be signed or acknowledged, dated and delivered either in writing or by electronic mail to the Director of Medical Staff Affairs prior to the meeting at which the absentee ballot is to be voted. If a member submits an absentee ballot and attends the meeting and votes at the meeting, the absentee ballot shall be deemed withdrawn.

6.5. Order of Business

6.5.1 The agenda at any regularly scheduled meeting of the Medical Staff, Department and committee shall be prepared, as applicable, at the direction of the President of the Medical Staff or chairperson prior to the meeting. It shall include those matters determined by the President of the Medical Staff or chairperson or otherwise requested by a member of the MEC.

6.5.2 The agenda at any special meeting of the Medical Staff, Department and committee shall include:

a. Reading of the notice calling the meeting;
b. Conduct of the business for which the meeting was called; and
c. Adjournment.

6.5.3 Deliberations of the Medical Staff shall be governed by parliamentary custom contained in the current edition of "Robert's Rules of Order, Revised", except as otherwise provided in these Bylaws or as ordered by a two-thirds (2/3) vote of the eligible voters present in person or represented by written absentee ballot at any meeting.

ARTICLE VII

CLINICAL DEPARTMENTS

In order to promote effective staff management and to enhance quality of medical care and continuing medical education, the Staff shall be organized into Departments.

7.1. Departments. A Department is composed of a group of physicians having professional activities in distinct and sometimes interrelated areas of medical/surgical practice. The Medical Staff is organized in to the following Departments:

1. Anesthesia
2. Emergency Outpatient
3. Family Practice
4. Hospitalists
5. Internal Medicine
6. Obstetrics and Gynecology
7. Pathology
8. Pediatrics
9. Psychiatry
10. Radiology
11. Surgery

7.2. Assignment to Departments. All practitioners approved for Medical Staff membership and/or clinical privileges are assigned to a Department by the Governing Board based upon the recommendation of the MEC. The Department so designated is the practitioner's

primary Department. The practitioner may also request and be granted clinical privileges in other Departments and, when exercising those clinical privileges, shall follow the policies of that Department.

7.3. Organization. A Department may be organized to include a Service Committee or other division that assists the departmental officers in the performance of their duties. The Service Committee is appointed by the Department Chairperson and is required to accomplish the duties of the Department. The presence of one-third (1/3) of the members of the Department Committee, either in person or represented by duly executed written absentee ballot, shall constitute a quorum for actions of the Committee.

7.4. Election of Department Chairpersons. Prior to the annual meeting of an election year, the President-Elect of the Medical Staff shall recommend a candidate for Chairperson of each Department for submission to a vote by the members of each Department. The name of this candidate shall be submitted to the members of the Department at a meeting prior to November 1st of that year. Additional nominations may be submitted in writing, to the President-Elect, no later than fourteen (14) days prior to the meeting. Only Active Staff members who are in good standing are eligible to vote and/or serve as a Department Chairperson or Vice Chairperson. A majority vote of those present, in person or by written absentee ballot, is required for election. If more than two (2) persons are nominated and no one candidate receives a majority of the votes, the two candidates receiving the most votes shall have a run-off election by absentee ballot.

A Chairperson may be nominated and elected from the ranks at this meeting. The Chairperson shall assume his/her duties on the first day of January following the election for a term of two (2) years. Any vacancy in Department Chairperson shall be filled by special election at the next regular meeting of the Department.

7.5. Duties of Department Chairperson

7.5.1 Department Chairperson.

a. Report to the President issues concerning the quality of care rendered to patients treated by members of his/her Department;

b. Be cognizant of the administrative and professional activities of the Department and its members;

c. Ensure that all functions essential to quality care are coordinated, including continued surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

d. Review any request by applicants, including APP/AHPs, for assignment to, or clinical privileges in, the Department or any request by a Medical Staff member for reappointment or modification of clinical privileges within the Department. The Chairperson shall submit a written report concerning the requested membership and/or clinical privileges to the Credentials Committee;

e. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

f. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital;

g. Be cognizant of the integration of the Department into the primary function of the Hospital, in addition to the coordination and integration of interdepartmental and intradepartmental services;

h. Participate in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

i. Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

j. Be cognizant of the orientation and continuing education of all persons in the Department or Service;

k. Identify and recommend space requirements and other resources needed by the Department;

l. Enforce the Medical Staff Bylaws, the Medical Staff Rules and Regulations and applicable Medical Staff and Hospital policies;

m. Serve as a member of the MEC;

n. Preside at all meetings of the Department;

o. Determine of the qualifications and competence of Department or Service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

p. Preside over the Department committee for the continuous assessment and improvement of the quality of care, treatment, and services in the Hospital and as an external review committee for other health care providers within the Corporation; and

q. Maintain of quality control programs, as appropriate.

7.5.2 Vice Chairperson. A Vice Chairperson, if elected by the Department, shall perform such duties as are assigned by the Chairperson and shall assume the duties and exercise the rights of the Chairperson during the absence of the Chairperson.

7.6. Recall and Removal of Department Chairpersons. Upon receipt of a petition seeking recall of an elected Department Officer, which has been signed by at least one-third (1/3) of the Department members eligible to have voted at the election, the Secretary-Treasurer shall call a special meeting of the Department to be held within thirty (30) days of receipt of said petition. If at this meeting, a quorum being present, two-thirds (2/3) of the eligible voters present in person or requested by duly executed written proxy vote for recall, the office shall be declared vacant. Any office so vacated by recall shall be filled by election conducted by the Department in accordance with Section 7.4. No removal is effective unless and until it has been ratified by the MEC and Governing Board.

ARTICLE VIII

ADVANCED PRACTICE PROFESSIONALS/ALLIED HEALTH PROFESSIONALS

8.1. Approved Professions. Advanced Practice Professionals/Allied Health Professionals are those licensed or certified individuals who the Governing Board has determined to be eligible to apply for clinical privileges consistent with the minimum eligibility and qualification requirements established by the Governing Board as described in Section 1.7 above and the MEC and Governing Board-approved APP/AHP credentialing policy, which will include their recognized scope of practice, licensure, certification, education, and demonstrated competency. Approved APP/AHP professions include but are not limited to: Dentists, Advanced Registered Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Physician Assistants, and Psychologists.

APP/AHPs who are eligible for and granted clinical privileges will be credentialed and privileged pursuant to the process as set forth in the Medical Staff Credentialing Manual. APP/AHPs are not entitled to the hearing and appeals procedures set forth in the Medical Staff's Corrective Action and Fair Hearing Plan. The corrective action and appeal procedures for APP/AHPs are provided for in the APP/AHP credentialing policy.

ARTICLE IX

QUALITY REVIEW

9.1. Quality Review. The Hospital's quality assurance program and related policies provide mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with clinical privileges. Monitoring and evaluating functions shall be performed for all clinical activities. Each Department and/or Section Chairperson is responsible for the implementation of the quality assurance plan for the Department.

9.1.1 Elements of Quality Monitoring and Evaluation. Monitoring and evaluation shall include the following:

a. Routinely collect information about important aspects of patient care provided in the Department and about the clinical performance of its members.

b. Periodically assess such information to identify opportunities to improve care and to identify important concerns in patient care.

c. Develop objective criteria that reflect current knowledge and clinical experience to implement the Department's collection and assessment activities.

d. Make recommendations or take actions and evaluate the effectiveness of the actions taken when important concerns in patient care and clinical performance or opportunities to improve care are identified.

e. Document quality assurance activities and report them regularly.

ARTICLE X

CONFLICT RESOLUTION

10.1. Conflict Resolution. If a conflict or dispute arises or is reasonably expected to arise regarding the adoption, amendment, or deletion of Bylaws, recommendations to adopt or change Rules and Regulations, policies, or any other issues in dispute between or among the MEC, the Medical Staff, Governing Board and/or Administration, then the Medical Staff, the MEC, Administration and the Governing Board should work collegially to resolve the conflict or dispute. All conflict resolution should initially occur through informal steps. An informal approach may include the use of external resources or a Hospital representative trained in conflict management to help facilitate the process. If a resolution cannot be reached through informal means, the matter may be referred to a Joint Conference Committee as described in Section 10.2 below.

If the conflict is between members of the Medical Staff and the MEC, the disputed matter shall be submitted to a Joint Conference Committee upon a petition signed by one-third (1/3rd)) of the Active Staff.

10.2. Joint Conference Committee

10.2.1 Composition: If the conflict or dispute is between or among the Medical Staff, Governing Board and/or Hospital Administration, the Joint Conference Committee shall be formed that will consist of three (3) members of the Governing Board and three (3) members of the Active Staff as selected by President of the Medical Staff. If the conflict or dispute is between the Medical Staff and the MEC, the Joint Conference Committee shall consist of the three (3) members of the MEC as selected by the President of the Medical Staff and three (3) members of the Active Staff as designated by the Active Staff submitting the petition. The Chairperson of the Committee shall either be the Chairperson of the Governing Board or the President of the Medical Staff, depending on whether the Governing Board is represented on the Committee. The Administrator, VPMA, and CMO shall serve as ex-officio members of the Committee without vote.

10.2.2 Duties: The Joint Conference Committee shall gather information regarding the conflict, meet to discuss various issues in dispute, and work in good faith to resolve the matter in a manner that protects safety and quality throughout the Hospital.

ARTICLE XI

CONFIDENTIALITY, AUTHORIZATION, REPORTING IMMUNITY, AND RELEASES

11.1. Special Definitions. For purposes of this Article, the following definitions shall apply:

a. "Information" means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in Section.

b. "Representative" means the Governing Board and any director/trustee, officer or committee thereof; the Hospital, its directors, officers and employees; the Medical Staff organization (Divisions/Departments, and committees) and its Offices, Division/Department Chairpersons and other practitioners; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

c. "Third Parties" means any individual or organization providing Information to any Representative.

11.2. Authorizations and Conditions. By submitting an application for appointment or reappointment to the Medical Staff, or by applying for or exercising clinical privileges at the Hospital, a practitioner:

a. Authorizes Representatives and Third Parties, as applicable, to solicit, provide and act upon Information bearing on his/her professional ability and qualifications.

b. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative and Third Party who acts in accordance with the provisions of this Article.

c. Acknowledges that the provisions of this Article are express conditions to his/her application for, acceptance of, and continuation of Medical Staff membership and/or to his/her exercise of clinical privileges at the Hospital.

11.3. Confidentiality of Information. Information with respect to any practitioner submitted, collected or prepared by any Representative of this or any other health care facility or organization or medical staff for the purpose of: evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care; evaluating the qualifications, competence, and performance of a practitioner or acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in compliance with the applicable standards of care; or, establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the Information is not needed, nor be used in any way except as provided in the Bylaws or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided to Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each practitioner that violation of the confidentiality provisions provided herein is grounds for immediate termination of Medical Staff membership and/or clinical privileges.

11.4. Immunity from Liability. Submission of an application for Medical Staff membership and/or for the exercise of clinical privileges in the Hospital constitutes a practitioner's express release of liability of the following:

a. For Action Taken: No Representative or Third Party, as applicable, shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not intentionally act on the basis of false Information knowing such Information to be false.

b. For Providing Information: No Representative or Third Party, as applicable, shall be liable to a practitioner for damages or other relief by reason of gathering or providing Information, including otherwise confidential or privileged Information, within the scope of his/her duties as a Representative or Third Party, provided that such Representative or Third Party does not intentionally act on the basis of false Information knowing it to be false.

11.5. Activities and Information Covered. The confidentiality and immunity provided by this Article applies to all Information in connection with this or any other health care facility's or Corporation's activities including, but not limited to:

a. Applications for appointment or clinical privileges.

b. Applications for reappointment, addition, or renewal of clinical privileges.

c. Corrective action.

d. Hearings and appellate reviews.

e. Performance improvement/quality assessment activities.

f. Utilization review/management activities.

g. Claims reviews.

h. Profiles and profile analysis.

i. Risk management activities.

j. Any other Hospital, committee, Department/Service, or Medical Staff activities related to evaluating, monitoring, and maintaining quality and efficient patient care and professional conduct.

11.6. Authorizations and Releases. Upon request of the Hospital, each practitioner shall execute general and specific authorizations and releases in accordance with this Article, subject to such requirements as may be applicable under federal and state law. Such authorizations and releases will operate in addition to the provisions of this Article. Execution of such authorizations and releases shall not be a prerequisite to the effectiveness of this Article. Failure to execute such authorizations and releases in connection with a corrective action shall be grounds for suspension of appointment and clinical privileges and such failure shall be construed as a failure to participate in the peer review process.

11.7. Strict Compliance Not Required. These Bylaws provide certain minimum procedures with respect to Medical Staff appointment and/or clinical privileges determinations concerning applicants to and members of the Medical Staff and other practitioners. Provided that the Medical Staff and Governing Board act in a manner consistent with these procedures, and other than the timeframe for a practitioner to request a hearing or appellate review (as set forth in the Corrective Action and Fair Hearing Plan), strict compliance by the Medical Staff or Governing Board with the procedures and timelines set forth in these Bylaws is not required. These Bylaws are not intended in any fashion to create legally binding contractual rights to strict compliance with their provisions. Accordingly, these Bylaws shall not be interpreted as, nor construed to be, a contract of any kind between the Hospital and the Medical Staff as a whole, or the Hospital or Medical Staff and any individual member, applicant or non-physician practitioner that requires strict compliance and shall not in any fashion give rise to any type of legal action, claim, or proceeding for breach of contract related to a failure to comply strictly with their provisions.

11.8. Cumulative Effect. Provisions in these Medical Staff Bylaws and in the application or other Hospital or Medical Staff forms relating to authorizations, confidentiality of Information and immunity from liability are in addition to, and not in limitation of, other protections provided by applicable law.

ARTICLE XII

ADOPTION, AMENDMENT, REPEAL OF BYLAWS

12.1. Medical Staff Bylaws. All proposed, amendments or restatements to the Medical Staff Bylaws, excluding the Rules and Regulations, should first be reviewed for input by the Corporation's bylaws committee or similar physician-led Corporation resource, then reviewed and recommended by the Bylaws Committee and MEC. Requests for action, amendment or restatement may also be made upon written request by at least ten percent (10%) of the Active Staff who are eligible to vote. All proposed amendments or restatements may be voted upon at any Medical Staff meeting after the proposed amendments or restatements have been published for at least thirty (30) days before the meeting. To be adopted, all amendments or restatements must receive a majority affirmative vote of those Active Staff who are in good standing, eligible and present or voting by absentee provided a quorum is present. Proxy voting is not permitted.

In the alternative, the MEC may present any proposed amendment or restatement to the voting Medical Staff, after first obtaining input by the Corporation's bylaws committee or similar physician-led Corporation resource, without a meeting and by written ballot to be duly executed and returned to Medical Staff Affairs by a date indicated by the MEC. Along with the proposed amendment or restatement, the MEC may provide a written recommendation on the proposed amendment or restatement. To be adopted, the amendment or restatement must receive a majority affirmative vote of those Active Staff who are in good standing and eligible who submit a vote in the manner and deadline specified by the MEC.

Adoption, amendment or repeal of the Medical Staff Bylaws shall be effective only after approval by the Governing Board. Neither the Medical Staff nor the Governing Board may unilaterally amend the Bylaws, which consist of this Governance and Organization Manual, the Medical Staff Credentialing Manual, and the Medical Staff Corrective Action and Fair Hearing Plan.

12.2. Technical Amendments. The MEC shall have the power to adopt such amendments to these Bylaws that are needed because of reorganization, renumbering, punctuation, spelling or other errors of grammar or expression without review and approval by the Medical Staff.

ARTICLE XIII

MEDICAL STAFF POLICIES AND RULES & REGULATIONS

13.1. Medical Staff Policies. The MEC, subject to Governing Board approval, may also adopt and amend various policies and procedures that shall be applicable to all members of the Medical Staff and other practitioners/non-physician practitioners who have been granted clinical privileges provided such policies do not conflict with these Bylaws, the Bylaws of the Governing Board, or applicable Federal and state law. All policies and policy amendments adopted and amended by the MEC and approved by the Governing Board

shall then be communicated to the Organized Medical Staff in a timely manner utilizing methods customarily used by Medical Staff Affairs.

Medical Staff policies may be adopted, amended, or repealed by a majority vote of the members of the MEC as more fully described in Section 6.2 above.

Medical Staff policies may also be proposed directly to the Governing Board by a petition signed by one-third (1/3rd) of the members of the Active Staff. All proposed policies and policy amendments must be presented to MEC for review and comment before such policy is voted by the Active Staff. All proposed policies and policy amendments become effective only after approval by the Governing Board.

13.2. Rules and Regulations. All Rules and Regulations and amendments under consideration by the MEC must first be communicated to the Organized Medical Staff for review and comment prior to the proposed Rules and Regulations or amendment being adopted and forwarded to the Governing Board for approval. Rules and Regulations may be adopted, amended, or repealed by a majority vote of the members of the MEC as more fully described in Section 6.2 above. Rules and Regulations and amendments adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner utilizing methods customarily used by Medical Staff Affairs.

Rules and Regulations may also be proposed directly to the Governing Board by a petition signed by one-third (1/3rd) of the members of the Active Staff. All proposed Rules and Regulations must be presented to MEC for review and comment before such Rules and Regulations are voted by the Active Staff. All proposed Rules and Regulations become effective only after approval by the Governing Board.

13.3. Urgent Amendments. In the event there is a documented need for an urgent amendment to the Rules and Regulations to comply with a law or regulation, the MEC may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be immediately notified by the MEC. Members of the Medical Staff may submit any comments regarding the provisional amendment to the MEC within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If one-third (1/3rd) of the Active Staff dispute the amendment, a Joint Conference Committee shall be formed pursuant to Section 10.2 herein.

13.4. Governing Board Approval. The adoption, amendment or repeal of the Medical Staff Rule and Regulations or policies shall not be effective unless and until it has been approved by the Governing Board.

ARTICLE XIV

MISCELLANEOUS PROVISIONS

14.1. Privileges and Immunities. The Governing Board, any committees and/or representatives of the Medical Staff and/or of the Governing Board that conduct credentialing, privileging and other peer review activities, constitute themselves as

professional review bodies and peer review committees as defined by the Health Care Quality Improvement Act and applicable Iowa law. Each professional review body and/or committee claims all privileges and immunities afforded to it by all applicable federal and state laws. Any action taken by a professional review body and/or committee pursuant to these Bylaws or related policy regarding an applicant to or member of the Medical Staff shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any Medical Staff applicant or member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

14.2. Effect of Headings and Table of Contents. Article and Section headings are for convenience only and shall not affect construction or meaning.

14.3. Severability Clause. In case any provision in these Bylaws shall be invalid, illegal, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired by such action.

14.4. Governing Law. These Bylaws shall be governed by, and construed in accordance with applicable Iowa law without effect to its conflict of laws principles.

14.5. Notices. All notices, requests, demands, reports, written statements and other communications required or permitted to be given to any Medical Staff applicant or member or non-physician practitioner shall be in writing and sent by United States certified or registered mail, return receipt requested, postage and registration or certificate prepaid, and shall be deemed given on the receipt of certified or registered mail, as evidenced by a signed receipt. Refusal to accept notice shall constitute constructive receipt effective the date of such refusal.

14.6. Confidentiality and Reporting. Actions taken and recommendations made pursuant to these Bylaws, related manuals and policies shall be treated as confidential in accordance with applicable federal and Iowa law and with such policies regarding confidentiality as may be adopted by the Governing Board. In addition, reports of actions taken pursuant to these Bylaws shall be made by the Administrator to such governmental agencies as may be required by law.

14.7. Cross References. Throughout the document, cross references are made to other sections of this document and to other related documents, such as the Corrective Action and Fair Hearing Plan. By reason of amendments, it is possible that cross references may not always be appropriately changed to conform to the intentions expressed in this or related documents. In such circumstances, such cross references shall be interpreted as applying (i) to the section or subsection designated at the time originally drafted, if such section or subsection is still included in the appropriate document, even though it may have been renumbered or amended, or (ii) to the section or subsection replacing such cross

referenced section or subsection, if the content of such replacement section or subsection is such as to be consistent with the original sense of the cross reference.

ARTICLE XV

DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including, but not limited to, the Hospital Administrator, Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO); Chief Medical Officer (CMO); Vice President of Medical Affairs (VPMA), Vice President Human Resources; and Associate Chief Nursing Officer (ACNO); and Associate Administrator.

Administrator or Hospital Administrator: The individual appointed by the Governing Board to act on behalf of the Hospital in the overall management of the Hospital. The Administrator holds the title of Administrator of the Hospital. In the event of his/her absence, the Administrator may select or arrange for a designee to temporarily serve in his or her capacity.

Advanced Practice Professional (APP)/Allied Health Professional (AHP): An individual who provides direct patient care services in the Hospital under a defined degree of collaboration or supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs, also known as AHPs, are those practitioners designated by the Governing Board from time to time to be credentialed through the Medical Staff process and are granted practice parameters as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. APPs include, but are not limited to, Dentists, Physician Assistants, certified Registered Nurse Anesthetists, Certified Nurse Midwives, Clinical Psychologists, and Advanced Registered Nurse Practitioners.

Adverse Action: Means an action to restrict, suspend, revoke, deny or not renew the Medical Staff membership and/or clinical privileges of a practitioner that is taken or made in the course of a professional review activity and is based on an evaluation of the practitioner's clinical competence or professional conduct. An adverse action shall entitle the practitioner to the procedural rights described in the Corrective Action and Fair hearing Plan, except as otherwise provided in the Bylaws.

Applicant: An individual, as defined by these Bylaws, who has submitted a complete application for appointment, reappointment, and/or clinical privileges.

Board Certification or Board Certified: A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and

experience necessary to provide quality patient care in that specialty and has maintained certification through retesting and completion of other maintenance of certification requirements. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon.

Bylaws: The Bylaws of the Medical Staff, which includes the Governance and Organization Manual, Credentialing Manual and Corrective Action and Fair Hearing Plan.

Clinical Privileges or Privileges: Authorization granted by the Governing Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment, individual character, and performance. Clinical privileges shall be setting-specific, meaning that the clinical privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department/Section Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Governing Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Governing Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Conflict Management: The identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality, and use of negotiating and listening skills.

Contract Practitioner: A practitioner providing care or services to Hospital patients through a contract or other arrangement.

Corporation: The legal owner of the Hospital, Genesis Health System, d/b/a Genesis Medical Center, Davenport.

CPCS: The Clinical Patient Care System, used to electronically document patient care (Cerner).

Criminal Action: Conviction, or a plea of guilty or no contest pertaining to any felony, involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation (CODA) and has a current, unrestricted license to practice dentistry.

Department: A clinical department of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Ex Officio: Serves as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the Medical Staff and Governing Board and incorporated into these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a Iowa health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

Focused Professional Practice Evaluation (FPPE): Focused professional practice evaluation is a Medical Staff-defined process whereby the privilege/procedure-specific competence of a practitioner who does not have documented evidence of competently performing the requested clinical privilege at the Hospital is evaluated. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Good Standing: The term "good standing" means a practitioner who, during the current term of appointment and/or term of clinical privileges, has maintained all qualifications for Medical Staff membership, his/her assigned category, and is in compliance or current with all applicable responsibilities, including on-call, dues payment, and medical record completion, and also is not currently subject to a limitation, suspension, restriction or FPPE (other than for initial/additional clinical privileged) related to Medical Staff membership and/or clinical privileges.

Governing Board: means the Board of Directors of Genesis Health System or authorized subcommittee, to which it has delegated authority.

Graduate Medical Education (GME): the second phase of medical education which prepares physicians for practice in a medical specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. §11101 et seq.

Healthcare Professional: An individual licensed, certified, or registered by Iowa, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Genesis Medical Center, Davenport Campus – 1227 East Rusholme Street, Davenport, IA. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State of Iowa and by the Hospital to provide patient care independently. The Governing Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

Medical Staff: The Medical Staff is the term referring to the practitioners designated by the Governing Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Governing Board has determined that the categories of practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

Medical Staff President (President of Medical Staff) : The member of the Active Staff who is elected in accordance with these Bylaws to serve as President of the Medical Staff of this Hospital. The Medical Staff President shall be a doctor of medicine or osteopathy who has been on the Active Staff for at least two (2) years, unless waived in unusual circumstances and remain a member in good standing during his/her term of office.

Medical Affairs: The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Services responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Services is accountable to Administration. The documents maintained by the Medical Staff Services are the property of the Hospital.

Medical Staff, Organized: The Organized Medical Staff is a formally organized body of the Medical Staff, who as a group, are responsible for establishing the Bylaws for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members and practitioners with clinical privileges. The Organized Medical Staff is limited to practitioners who are members of the Active Staff category of membership and have therefore been granted the rights to vote and to hold Office in the Organized Medical Staff.

Medical Staff Year: The period from January 1 to December 31 of each year.

Member: All physicians, oral maxillofacial surgeons, and podiatrists who have been granted and maintain Medical Staff membership under these Bylaws.

Membership: The approval granted by the Governing Board to a qualified physician, oral maxillofacial surgeons, and podiatrists to be a member of the Medical Staff.

Moonlighting Resident: A current resident in an approved program who has received approval from the residency program director to apply to provide evaluation and treatment of patients in approved clinical areas, under observation of a sponsoring physician.

Ongoing Professional Practice Evaluation (OPPE): Ongoing professional practice evaluation is the continuous evaluation of the practitioner's professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process.

Oral Maxillofacial Surgeon Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures consistent with the Iowa peer review statute and/or the Iowa risk management statutes

With reference to practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

Physician: A duly licensed doctor of medicine or osteopathy legally authorized to practice medicine and surgery.

Podiatrist: A duly licensed doctor of podiatric medicine legally authorized to practice podiatry.

Practice Parameters: Specifically designated patient care services as are under the control, responsibility and supervision of the employing or consulting member of the medical staff. Authorization granted by the Governing Board to an APP to provide direct patient care services in the Hospital under a defined degree of supervision.

Professional Review Action: Means an action to reduce, restrict, suspend, revoke, deny or not renew a practitioner's Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the practitioner's clinical competence or professional conduct. A professional review action shall entitle the practitioner to the procedural rights afforded by the Corrective Action and Fair Hearing Plan, except as provided in these Bylaws. This term is synonymous with "adverse action."

Professional Review Activity: A formal investigation or other activity of a professional review body with respect to a member or practitioner applicant to determine whether the member or practitioner applicant may have clinical privileges or Medical Staff membership; to determine the scope or conditions on such clinical privileges or Medical Staff membership, or to change or modify such clinical privileges or membership.

Professional Review Body: A committee, subcommittee or other body that engages in professional review activities for the purpose of furthering the delivery of quality healthcare. The designation of "Professional Review Body" includes but is not limited to any committee or subcommittee constituted to perform peer review activities as a component of its responsibilities, including the Governing Board.

Qualified Medical Person or Personnel: In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals in the following professional categories who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his/her license and policies of the Hospital, have been approved by the Governing Board as Qualified Medical Personnel: Registered Nurse in Perinatal Services and newborn areas; an ARNP or physician assistant for low acuity Emergency Department/Section patients per their protocol; a registered nurse or an ARNP/PA for ground or air transport.

Referring Physician: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Residency Program – The unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the program requirements of a particular specialty.

Resident – A physician at any level of GME in a program accredited by the Accreditation Council of Graduate Medical Education (ACGME) or by the American Osteopathic Association.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Department/Sections and Divisions as approved by the Medical Executive Committee and Governing Board.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Iowa.

Teaching Staff – physicians of the Genesis Medical Center Medical Staff who supervise the clinical activities of residents and medical students.

Vice President of Medical Affairs: The Administrator serving as the liaison to the Medical Staff. He or she assists with coordination of the Medical Staff's credentialing, privileging, performance improvement, and quality assurance activities, Hospital Administration - Medical Staff liaison functions, and overall clinical organization of the Hospital and Medical Staff.