BYLAWS OF THE MEDICAL STAFF
JACKSON COUNTY REGIONAL HEALTH CENTER
MAQUOKETA, IOWA

July 15, 2014

PREMABLE

WHEREAS, Jackson County Regional Health Center is a county public hospital established and operated under the laws of the State of Iowa; and

WHEREAS, its purpose is to serve as the primary health resource for the community, providing health care, health maintenance and health education services that appropriately anticipate and respond to the needs of the people residing in its service area; and

WHEREAS, the Governing Board has delegated authority to the Medical Staff to assure the quality of medical and professional services provided by individuals with approved clinical and practice privileges, and the Medical Staff accepts accountability for those services; and

WHEREAS, it is recognized that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Board are necessary to fulfill the foregoing responsibilities of the Medical Staff and the Hospital's obligations to its patients;

NOW, THEREFORE, through the adoption of these Bylaws the Medical Staff of the Jackson County Region Health Center, organize for self-governance in accordance with

1. CMS Conditions of Participation for Critical Access Hospitals, The Joint Commission standards and requirements of other regulatory and accreditation agencies to which the facility is accountable
2. These bylaws create no rights, liabilities, restrictions, or prerogatives unless accounted for, supported by, or permitted in these governing sources
3. Upon approval, these bylaws are binding on the Governing Board and the members of the Medical Staff of Jackson County Regional Health Center.
4. With their adoption these bylaws supersede any previously approved versions of the bylaws.
5. In construing these Bylaws and Rules and Regulations the Medical Staff may take into account its usual and customary policies and practices, common understanding of the language and terms used, whether written or unwritten, and may also bring to bear the expert knowledge of members of the Medical Staff,.
6. All captions and titles used in these Bylaws and Rules and Regulations are for convenience only and shall not limit or otherwise affect in any way the scope or manner of interpretation of any provision. The Medical Executive Committee shall have the authority to resolve issues of interpretation and application of these Bylaws, Rules and Regulations in accordance with laws, regulations, policies and requirements of regulatory or accrediting agencies.

DEFINITIONS

1. CHIEF EXCECUTIVE OFFICER means the person appointed by the Governing Board to act on its behalf in the overall management of the Hospital, or his authorized representative. The Executive Director is the President or Chief Executive Officer (CEO) of the Hospital.
2. ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a doctor of medicine or osteopathy, dentist, podiatrist, or psychologist, who exercises independent judgment within the areas of his professional competence and the limits established by the Governing Board, the Medical Staff and the applicable State Practice Acts, who is qualified to render health services under the supervision or direction of a Medical Staff member in good standing. AHPS are not eligible for Medical Staff membership or privileges, but are eligible to request and be granted practice privileges and prerogatives in conformity with these Bylaws approved by the Governing Board, and the Medical Staff Rules and Regulations.
3. CHIEF OF SERVICE means the Medical Staff member duly appointed in accordance with these Bylaws to serve as the head of a recognized Hospital clinical service.
4. CHIEF OF STAFF means the highest elected official of the Medical Staff.
5. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member or an Allied Health Staff to render specific diagnostic, therapeutic, medical, surgical, dental, podiatric, or psychological services.
6. MEDICAL EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Board.
7. GOVERNING BOARD means the Board of Trustees of the Hospital.
8. HE AND HIS mean the masculine and feminine gender as the context and circumstances require.
9. HOSPITAL means Jackson County Regional Health Center.
10. MEDICAL STAFF or STAFF means the formal organization of doctors of medicine or osteopathy, dentists, podiatrists and psychologists who are privileged to attend patients in the Hospital.
11. MEDICO-ADMINISTRATIVE OFFICER means a practitioner, employed or engaged as an independent contractor by the Hospital on a full-time or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners or employees under his direction.
12. PHYSICIAN as defined by CMS means an individual with an M.D. or D.O., dentist, or podiatrist who is fully licensed to practice medicine.

13. PRACTITIONER means, unless otherwise expressly limited, any physician, dentist, podiatrist, or psychologist who is applying for Medical Staff membership and/or clinical privileges, or who is a Medical Staff member and/or who exercises clinical privileges in the Hospital.
14. PREROGATIVE means a right granted to a Medical Staff member, by virtue of Staff category or otherwise, which is exercisable in accordance with the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules, regulations, or policies.
15. SERVICE means that group of practitioners or AHP's who have clinical or practice privileges in one of the general areas of Medicine; Surgery-Anesthesia; Radiology-Nuclear Medicine, Ultrasound, and CT; Pathology/Clinical Laboratory; and Emergency.

ARTICLE I: NAME

The name of this organization shall be The Medical Staff of Jackson County Regional Health Center.

ARTICLE II: PURPOSE

The purpose of this organization shall be:

1. To establish the medical staff as a self-governing and organized entity with the understanding that the Medical Staff may make recommendations to the Governing Body, but is subject to the ultimate authority of the Governing Body
2. To assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital, receive the appropriate level and quality of care.
3. To assure a fully acceptable level of professional performance of all Practitioners and AHP's authorized to practice in the Hospital, through the appropriate delineation of the clinical and practice privileges that each may exercise, and through an ongoing review and evaluation of the care rendered by practitioners and AHPs in the Hospital.
4. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Board and Chief Executive Officer.
5. To initiate and maintain rules and regulations for the Medical Staff to carry out its responsibility to be self-governing with respect to the professional work performed in the Hospital, pursuant to the authority delegated by the Governing Board.
6. To establish the authority and responsibilities of the organized medical staff.
7. To define the structure of medical staff.
8. To define and describe the qualifications, prerogatives and rights and responsibilities of members of the medical staff.
9. To delineate the mechanism for the credentialing and privileging of physicians and other healthcare professionals.

ARTICLE III. MEMBERSHIP

3.1 ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP

3.1-1 IN GENERAL

Medical Staff membership and clinical privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, Standards and requirements set forth in these Bylaws. Appointment to and Membership on the Medical Staff shall confer on the member only such clinical privileges and prerogatives as have been granted by the Governing Board in accordance with these Bylaws. No practitioner shall admit patients or provide or order services to patients in the Hospital unless he is a

member of the Medical Staff or has been granted privileges in accordance with the procedures set forth in these Bylaws.

3.1-2 Individuals eligible for medical staff membership

1. Hold an active, current, full and unrestricted license to practice in the state of Iowa.
2. Are able to participate in Medicare or Medicaid, or other federal agencies with no current sanctions or restrictions.
3. Have no adverse reports from the Office of Inspector General for civil or criminal charges or exclusions to participate in federally funded healthcare programs.
4. Have graduated from an accredited professional school in their respective discipline or have graduate from a foreign medical school and hold a certificate from the Educational Commission for Foreign Medical Graduates.
5. Have completed a minimum of one year post graduate training, required for medical or osteopathic physicians,
6. Exhibit current competence as evidenced by references from current employer or education program and peer, consistent with the privileges requested.
7. Possess English-language proficiency
8. Maintain professional liability insurance as required by the Governing Board.
9. Hold a valid DEA certificate.
10. Maintain a level of physical and mental health that allows full participation in carrying out requested privileges.
11. Are able to work cooperatively with other health professionals as verified by professional references with current knowledge of the applicant.
12. Agree to notify the Chief of Staff or Hospital CEO promptly of changes in licensure; of any restriction, denial or surrender of clinical privileges or membership at another healthcare facility; any professional liability claim and any criminal charge with the exception of a minor traffic violation.
13. Request clinical privileges consistent with education, competence and experience.
14. Understand and agrees that granting of requested privileges is based on the needs of the institution and the capability of the organization to support the requested privileges.
15. Agree to maintain CME as required by applicable state licensing agencies and facility requirements.
16. Is board eligible or certified; required for new applicants to the medical staff.
17. Agree to respect the rights of patients.
18. Attests to having read and agreed to abide by the Bylaws, Rules and Regulations of the Medical Staff.
19. Agree to abide by Medical Staff and administrative policies of the Hospital.

20. Submits a current photograph from a state or federal source (Driver's license, Passport) or a photo ID from current employer.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Applicants to the Medical Staff must meet the following qualifications of membership

1. Doctors of Medicine or Osteopathy must have obtained a MD or DO from a program accredited by the American Association of Medical Colleges, or the American Osteopathic Association, professional schools accredited at the time the degree was conferred or have passed the appropriate U.S. sponsored foreign medical qualifying exam, have completed a minimum of one year of professional training in a United States (or equivalent) accredited training.
2. Dentists must have obtained a DDS or DMD degree from a program, which at the time the degree was conferred, was accredited by the Commission on Dental Accreditation of the American Dental Association.
3. Podiatrists must have obtained a DPM from a program accredited by the American Podiatric Medical Association, or having been otherwise determined by the Board to meet the Association standards.
4. Clinical Psychologists must hold a Doctorate from American Psychologist's Association or Council for National Register of Health Providers accredited school.

3.3 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, age, race, creed, color, national origin, handicap, religious affiliation, sexual preference or any other non-patient care factors, to professional qualifications, the Hospital's purposes, needs and capabilities, or community needs.

3.4 MEDICO-ADMINISTRATIVE OFFICERS

A practitioner who is employed by the Hospital or engaged as an independent contractor in a medico-administrative position must be a Medical Staff member, achieving his status by the procedure provided in Articles III and IV. The Medical Staff membership and clinical privileges of any medico-administrative officer shall also be subject to the terms and conditions of his contract or agreement with the Hospital. The contract or agreement shall govern over these Medical Staff Bylaws as to all matters covered by the contract or agreement. Unless a contract or agreement executed after the adoption of this provision provides otherwise, only those privileges made exclusive or semi-exclusive will automatically terminate, without the right of access to the due process and hearing procedures of Articles VI and VII of these Bylaws, with the termination of the medico-administrative officer's contract or agreement.

It shall further be the responsibility of all medico-administrative officers to provide in the contracts or agreements that they have with practitioners of AHP partners, employees, subcontractors and the like (herein referred to as "subcontractors") that privileges made exclusive or semi-exclusive to the holder of a contract or agreement, are likewise subject

to automatic termination upon agreement with the Hospital, or upon termination by the medico-administrative officer of his employment of, association with, or partnership with the subcontractor. Failure of a medico-administrative officer to include such provisions in his agreements with contractors shall not, affect the Hospital's, right to deem or determine that the privileges of subcontractors have been automatically terminated in accordance with the provisions of this section.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff shall:

1. Provide his patients with care at the generally recognized professional level of quality and efficiency established by the Hospital under its medical review standards.
2. Retain responsibility within his area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he is providing services, or arrange for a suitable alternative to assure such care and supervision.
3. Abide by the Medical Staff Bylaws and Rules and Regulations and by all other lawful standards, policies and rules of the Hospital.
4. Comply with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations, including but not limited to those requiring attendance at meetings, maintenance of professional liability insurance, and refraining from unlawful fee-splitting. It shall be understood that a compensation arrangement involving payment by a group practice to a physician member of the group practice is not unlawful fee-splitting.
5. Discharge such personal, Medical Staff, Service, Committee and Hospital functions, including but not limited to peer review, patient care audit, utilization review, and emergency room coverage and back up functions, for which he is responsible by virtue of his Staff category assignment, appointment, election, utilization of AHP's, or exercise of privileges, prerogatives, or other rights in the Hospital.
6. Prepare and complete in timely fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital.
   a. Complete a timely history and physical for patients admitted to the hospital under their name. Each member of the medical staff who is authorized to admit patients to the hospital shall ensure the completion of a history and physical examination according to medical staff rules and regulations, and hospital policies.
   b. A medical history and physical examination shall be completed no more than thirty (30) days before or no later than twenty-four (24) hours after admission to the hospital, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oro-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. A copy of history and physical completed 30 days prior to admission must be placed in the patient's current inpatient record.

c. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oro-maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

d. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

7. Abide by the lawful ethical principles or his profession.

   a. Notify the CEO or designee, such as administrator on call, within twenty-four (24) hours of each of the following events and provide such additional information as may be requested regarding:

   b. Voluntary or involuntary revocation, limitation, or suspension of his/her professional license, Drug Enforcement Administration (DEA) registration, or Iowa Controlled Substances Act (CSA) certificate (if applicable); any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license; or the imposition of terms of probation or limitation by any state;

   c. Voluntary or involuntary loss or restriction of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;

   d. Voluntary or involuntary cancellation or change of professional liability insurance coverage;

   e. Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Iowa;

   f. Receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital; and

   g. Receipt of notice of any state or federal felony charges or convictions.

   h. Failure to provide the above information within 24 hours may constitute grounds for automatic withdrawal of an Applicant's application or automatic termination of a Member's Clinical Privileges and Medical Staff membership. Applicants whose applications are deemed withdrawn pursuant to this provision and Members whose Clinical Privileges and membership are terminated pursuant to this provision are not entitled to fair hearing and appeal right.

8. Aid in educational programs for Medical Staff members, AHP's, and Hospital personnel when requested and as appropriate.
9. Assist the Hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his professional competence and credentials.

3.6 DURATION OF APPOINTMENT

Initial appointments to the Medical Staff shall be for a period of twenty-four months. Except as otherwise recommended by the Medical Executive Committee and approved by the Governing Board, initial reappointments shall extend to the date of the practitioner's next birthday. Subsequent reappointments shall be done on the practitioner's birthday and shall be for a period of not more than two (2) full years. For the purpose of these Bylaws, the Medical Staff year commences on the first day of January and ends the last day of December of each year.

3.8 LEAVE OF ABSENCE

3.8 -1- LEAVE STATUS

A Medical Staff member may request a leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and the CEO stating the approximate period of time of the leave, which may not exceed two (2) years. The request may be granted by the Medical Executive Committee, subject to such conditions or limitations as the Committee shall determine to be appropriate. During the period of the leave, the member's Hospital privileges, prerogatives, and responsibilities shall be suspended.

Any medical staff member who seeks to resume his or her hospital practice following a leave of absence shall be required to meet with the Medical Executive Committee prior to resuming practice, for the purpose of ascertaining whether privileges should be reinstated and whether any expansion, restriction or modification of the individual's practice is indicated.

A member of the Medical Staff or Allied Health Professional Staff whose appointment is due to expire during the period of the leave of absence, shall submit an application for reappointment as described in these Bylaws.

3.8-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave, or at any earlier time, the Medical Staff member shall request reinstatement of his privileges and prerogatives by submitted a written notice to that effect to the CEO and to the Medical Executive Committee. The Staff member shall submit a written summary of his relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of his privileges and prerogatives. Thereafter, the procedure set forth in Sections 6.3-5 through 6.3-8 shall be followed.

Failure, without good cause, to complete required reappointment application forms during a leave of absence, to request reinstatement or to provide a summary of activities shall be deemed to be a voluntary resignation form the Medical Staff and shall result in termination of membership, privileges, and prerogatives. A practitioner whose membership, privileges, and prerogatives are so terminated shall be entitled to the procedures provided in Article IX, for the sole purpose of determining whether the failure was with or without good cause. A request for Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into Active, Courtesy, Consulting, Emergency Services, Associate, Provisional, Honorary and Reference categories.

4.2 ACTIVE MEDICAL STAFF

4.2-1 QUALIFICATIONS

The Active Medical Staff shall consist of MDs and DOs, dentists, podiatrists and psychologists who:

1. Meet the qualifications set forth in Section 3.2.
2. Regularly admit patients to, or otherwise regularly provide professional services for patients in the Hospital.

4.2-2 PREROGATIVES

The prerogatives of an Active Medical Staff member shall be to:

1. Admit patients or provide services for patients consistent with privileges granted by the Governing Body.
2. Hold office in the Medical Staff and in the service and committees of which he is a member, and serve on committees
3. Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the service and committees of which he is a member.

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

1. Meet the basic responsibilities set forth in Section 3.5.
2. Actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his professional competence as described in policy.

COURTESY STAFF

4.2-4 QUALIFICATIONS

The Courtesy Staff shall consist of MDs or DOs, dentists, podiatrists, or psychologists who:

1. Meet the requirements set forth in Section 3.2.
2. Admit, or otherwise provide professional services for, not more than five (5) patients in the Hospital during any month.
3. Are members in good standing of the Active Medical Staff of another accredited or Medicare-certified hospital
4. Physicians who desire Courtesy Staff privileges after having practiced a minimum of ten consecutive years as a member in good stand of the Hospital's Active Medical Staff need not be a member in good standing of the Active Medical Staff of another Hospital and meet the eligibility requirements of Section 3.1.

4.2-5 PREROGATIVES

The prerogatives of a Courtesy Staff member shall be to:

1. Admit, or provide professional services for, not more than five (5) patients in the Hospital during any month. Members whose activity exceeds this limit must apply and qualify for Active or Consulting Staff status.
2. Exercise such clinical privileges as are granted to him pursuant to Article VII.
3. Attend meetings of the Medical Staff and the Service of which he is a member. A Courtesy Staff member may be requested to serve on standing or special committees, but may not hold office in the Medical Staff or in the Service of which he is a member.
4. A Courtesy Staff member may not vote for Medical Staff officers, on Bylaws amendments, on matters presented at general and special meetings of the Medical Staff, nor of the service or committees of which he is a member.

4.2-6 RESPONSIBILITIES

Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.5, except as may be modified for (e).

4.4 CONSULTING STAFF

4.4-1 QUALIFICATIONS

The Consulting Staff shall consist of MDs or DOs, dentists, podiatrists, or psychologists who:

1. Meet the qualifications set forth in Section 3.2, except that this requirement shall not preclude an otherwise qualified practitioner licensed in another state from appointment within the limitations of Iowa law.
2. Possess recognized clinical ability and come to the Hospital when so scheduled or when called to render a clinical opinion or service within their competence.
3. Are members in good standing of the Active Medical Staff of another hospital.

4.4-2 PREROGATIVES

The prerogatives of a Consulting Staff member shall be to:

1. Exercise such clinical privilege as are granted to him pursuant to Article VII.
2. Attend meetings of the Medical Staff and the service of which he is a member. A Consulting Staff member may not hold office in the Medical Staff or in the Service of which he is a member, or serve on standing committees.

3. A Consulting Staff member may not vote for Medical Staff officers, on Bylaws amendments, on matters presented at general and special meetings of the Medical Staff, nor of the service or committees of which he is a member.

4.4-3 RESPONSIBILITIES

Each Consulting Staff member shall meet the basic responsibilities set forth in Section 3.5, except as may be modified for (e).

4.5 EMERGENCY SERVICES STAFF

4.5-1 QUALIFICATIONS

The Emergency Services Staff shall consist of MDs or DOs who are employed or engaged as independent contractors by the Hospital for the limited purpose of providing medical coverage for the Hospital emergency room, and who meet the qualifications set forth in Section 3.2.

4.5-2 PREROGATIVES

The prerogatives of an Emergency Services Staff member shall be limited to:

1. Assessing, stabilizing, and treating patients in the emergency room, and providing medical services in response to in-house emergencies or as may be otherwise agreed upon within the Hospital; and
2. Exercising such clinical privileges as are granted pursuant to Article VII.
3. An Emergency Services Staff member may admit patients to the Hospital.
4. May not hold office in the Medical Staff or in the Service of which he is a member
5. An Emergency Service Staff member may he not vote for Medical Staff officers, on Bylaws amendments, on matters presented at general and special meetings of the Medical Staff, nor of the service or committees of which he is a member.

4.5-3 RESPONSIBILITIES

Each Emergency Services Staff member shall meet the basic responsibilities set forth in Section 3.5, except as may be modified for (e).

4.6 ASSOCIATE STAFF

4.6-1 QUALIFICATIONS

The Associate Staff shall consist of dentists, podiatrists, and psychologists who:

1. Meet the qualifications set forth in Section 3.2.
2. Admit and treat patients only by co-admitting each patient with a physician member of the Medical Staff who has admitting privileges and who assumes, as required by Section 7.3 hereof, responsibility for the care of the patient's medical problems.

4.6-2 PREROGATIVES

The prerogatives of Associate Staff members shall be to:

1. Admit and treat patients only by co-admitting each patient with a physician member of the Medical Staff who has admitting privileges who assumes, as required by Section 7.3 hereof, responsibility for care of the patient's medical problems.
2. Exercise such clinical privileges as are granted to him pursuant to Article VII.

3. Attend meetings of the Medical Staff and service of which he is a member. A member of the Associate Staff may hold office in the Medical Staff but may vote on any matters presented at general and special meetings of the medical staff that are related to their areas of practice.

4.6-3 RESPONSIBILITIES

Each Associate Staff member shall meet the basic responsibilities set forth in Section 3.5.

4.8 HONORARY STAFF

4.8-1 QUALIFICAITONS

The Honorary Staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous longstanding service to the Hospital.

4.8-2 PREROGATIVES

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. They may, however, attend Staff and Service meetings and any Staff or Hospital education meetings. An Honorary Staff member may not vote on any Medical Staff matter, hold office in the Medical Staff or in the Service of which he is a member, or serve on committees.

4.8-3 RESPONSIBILITIES

Each Honorary Staff member shall meet the basic responsibilities specified in Section 3.5, Paragraphs (c), (d), and (g).

4.9 There is no requirement for this category – the hospital only needs to verify the license of practitioners who refer a patient for tests

4.10

ARTICLE V: ALLIED HEALTH PROFESSIONALS

The Governing Board, in consultation with the Medical Executive Committee, shall determine the services to be provided in the Hospital and the categories of Allied Health Professionals (AHPs) eligible to provide services in the Hospital. Allied health professionals, if any, as required by Iowa law, which authorize the AHPs to provide certain professional services, are not eligible for Medical Staff membership.

5.1 ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP

Individuals eligible for medical staff membership

1. Hold an active, current, full and unrestricted license to practice in the state of Iowa or in another state as allowed by Iowa law.
2. Are able to participate in Medicare or Medicaid, or other federal agencies with no current sanctions or restrictions.
3. Have no adverse reports from the Office of Inspector General for civil or criminal charges or exclusions to participate in federally funded healthcare programs.

4. Have graduated from an accredited professional school in their respective discipline.
5. Hold Board Certification for their specific discipline.
6. Exhibit current competence as evidenced by references from current employer or education program and peer, consistent with the privileges requested.
7. Possess English-language proficiency
8. Maintain professional liability insurance as required by the Governing Board.
9. Hold a valid DEA certificate, if granted prescribing privileges.
10. Maintain a level of physical and mental health that allows full participation in carrying out requested privileges.
11. Are able to work cooperatively with other health professionals as verified by professional references with current knowledge of the applicant.
12. Agree to notify the Chief of Staff or Hospital CEO promptly of changes in licensure; of any restriction, denial or surrender of clinical privileges or membership at another healthcare facility; any professional liability claim and any criminal charge with the exception of a minor traffic violation.
13. Request clinical privileges consistent with education, competence and experience.
14. Understand and agrees that granting of requested privileges is based on the needs of the institution and the capability of the organization to support the requested privileges.
15. Agree to maintain CME as required by applicable state licensing agencies and facility requirements.
16. Agree to respect the rights of patients.
17. Attests to having read and agreed to abide by the Bylaws, Rules and Regulations of the Medical Staff.
18. Agree to abide by Medical Staff and administrative policies of the Hospital.
19. Submits a current photograph from a state or federal source (Driver's license, Passport) or a photo ID from current employer.

5.2 QUALIFICATIONS

1. Masters-prepared nurse practitioners must be a licensed registered nurse and must have obtained a master's degree from a program accredited by the Commission on Collegiate Nursing Education; in addition they must hold appropriate certification from a national certifying agency recognized by the National Council of State Boards of Nursing and provide evidence of prescribing and dispensing authority.
2. Certified Nurse-Midwives must be licensed registered nurses and hold current certification by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board (AMCB) (formerly known as ACNM Certification Council, Inc.) and have graduated from a post-baccalaureate midwifery education program that is accredited by the ACNM Division of Accreditation. A Master's degree with a major in Midwifery or Public Health is

strongly recommended. A CNM must also provide evidence of prescribing and dispensing authority.

3. Certified registered nurse anesthetists must have graduated from a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs with training in the science of anesthesia and be certified by the American Association of Nurse Anesthetists' Council on Certification of Nurse Anesthetists and be re-certified, as applicable, by the American Association of Nurse Anesthetists' Council on Recertification of Nurse Anesthetists. They must also provide evidence of prescribing and dispensing authority.
4. Physicians assistants must have obtained a degree from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant and must be certified by the National CCPA

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

An AHP must apply and be granted clinical privileges. Applications for initial granting of practice privileges, and biannual renewal thereof, shall be submitted and processed in a parallel manner to that provided in Articles III and IV for practitioners.

Each AHP shall be assigned to the clinical service appropriate to occupational or professional training and granted clinical privileges.

5.4 PRERORGATIVES

The prerogatives extended to an AHP include:

1. Provision of specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification.
2. Service on Medical Staff, department and Hospital committees without a vote.
3. Attendance at meetings of the department to which he is assigned without a vote
4. Attendance at Hospital education programs.

5.5 RESPONSIBILITIES

Each member of the Allied Health Professional Staff shall:

1. Provide his patients with care at the generally recognized professional level of quality and efficiency established by the Hospital under its medical review standards.
2. Retain responsibility within his area of professional competence for the care of each patient in the Hospital for whom he is providing services.
3. Abide by the Medical Staff Bylaws, Rules and Regulations and by all other lawful standards, policies and rules of the Hospital.
4. Comply with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations, including but not limited to those requiring attendance at meetings and maintenance of professional liability insurance.
5. Prepare and complete in timely fashion the medical and other required records for all patients he provides care to.

6. Abide by the lawful ethical principles or his profession.
7. Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs in supervising initial appointees of his same occupation or profession, or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.
8. Notify the CEO or designee within twenty-four (24) hours of each of the following events and provide such additional information as may be requested regarding:
    a. Voluntary or involuntary revocation, limitation, or suspension of his/her professional license, Drug Enforcement Administration (DEA) registration, or Iowa Controlled Substances Act (CSA) certificate (if applicable); any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license; or the imposition of terms of probation or limitation by any state;
    b. Voluntary or involuntary loss or restriction of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
    c. Voluntary or involuntary cancellation or change of professional liability insurance coverage;
    d. Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Iowa;
    e. Receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital; and
    f. Receipt of notice of any state or federal felony charges or convictions.
    g. Failure to provide the above information within 24 hours may constitute grounds for automatic withdrawal of an Applicant's application or automatic termination of a Member's Clinical Privileges and Medical Staff membership. Applicants whose applications are deemed withdrawn pursuant to this provision and Members whose Clinical Privileges and membership are terminated pursuant to this provision are not entitled to fair hearing and appeal right.
9. Abide by the same provision applicable to practitioners in Sections 11, 13 and 14 of the Medical Staff Rules and Regulations, entitled, "Chemically Impaired Practitioners", Harassment and Complaint Procedure" and "Disruptive Practitioners", respectively.

5.6 TERMINATION OF PRIVILEGES

An AHP's privileges shall automatically terminate in the event:

1. The Medical Staff membership of the supervising physician, if any, is terminated, whether such termination is voluntary or involuntary.
2. The supervising physician, if any, no longer agrees to act as the supervising physician for any reason, or the relationship between the AHP and the supervising physician, if any, is otherwise terminated, regardless of the reason therefore.
3. The AHP's license or certification expires, is revoked, or is suspended.

4. The AHP fails to maintain the required professional liability insurance coverage. The AHP's privileges may also be terminated by the Chief of the Service to which he is assigned, the Chief of Staff or the Hospital CEO.

5.7 REVIEW PROCEDURE

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the hearing and appeal rights applicable to members of the Medical Staff. However, in actions taken against a member of the AHP staff for reasons other than automatic termination of privileges for the reasons specified above, the AHP shall have the right to file a written grievance with the Chief of the clinical service to which the AHP has been assigned and in which he has practice privileges or the right to render the services in question within 15 days of such action.

Upon receipt of such a grievance, the Chief shall conduct an investigation that affords the affected AHP as opportunity for an interview before the Service Committee, which shall be appointed by the Chief of the Service. The committee shall include, for the purpose of this interview, the Service Chief, an AHP holding the same or similar license or certificate as the affected AHP if available, the Hospital CEO or his designate, and such other Hospital or Medical Staff members as the Chief deems appropriate under the circumstances. The interview shall not constitute the same type of "hearing" as is established for members of the medical staff, and shall not be conducted according to the procedural rules applicable with respect to hearings set forth in Article IV of these Bylaws. Before the interview, the affected AHP shall be informed of the general nature of the circumstances giving rise to the action or proposed action, and at the interview, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. A report of the findings and recommendations shall be made by the Service Chief to the Medical Executive Committee which shall act thereon. The action taken by the Medical Executive Committee shall be subject in all cases to approval by the Governing Board, whose decision shall be final and binding.

In no case shall clinical privileges or Staff appointment survive the termination of any contract between the Hospital and an allied health professional for the provision of professional or administrative services nor shall termination of privileges pursuant to termination of the contract entitle the allied health professional to any hearing and appeal procedures not specifically provided for in the contract. Specific contractual terms shall, in all cases, be controlling in the event that they conflict with provisions in the Hospital or Medical Staff Bylaws, Rules, and Regulations.

5.8 SURGICAL ASSISTANTS

Surgical Assistants are persons who are not employees of the Hospital, and who are not members of the Medical Staff or of the regular Allied Health Professional Staff, but who work from time to time in the Hospital and are employed by and responsible to members of the Medical Staff and who work under the Medical Staff member's direction and supervision. Supervising Medical Staff members shall show proof of liability insurance covering the surgical assistant. All Surgical Assistants who request privileges shall do so on an appropriate form approved by the Governing Body. Applicants shall submit information pertaining to their educational background and their experience and training in the specialty in which the privileges are requested. Surgical Assistants shall be

governed by the Termination of Privileges and Review Procedure as set forth in this Article V.

5.8.1 NON-PHYSICIAN FIRST ASSISTANT AT SURGERY

Non-physician First Assist at Surgery work under the direct supervision of a Medical Staff member. The Chair of Surgery will sign off on all privileges requested, which shall be processed in accordance with those for Allied Health credentialing.

Prerogatives

1. Provide specified patient care services under the direct supervision of a member of the Medical Staff.
2. Exercise such other prerogatives as shall be accorded any specific category of AHP as are approved by the Medical Executive Committee.
3. May not vote at committee or department meetings.
4. Shall be assigned to a department based on privileges granted.

The first assistant at operative procedures will be chosen by the operating surgeon based on the surgeon's evaluation of the level of competence of the assistant and the level of competence required by the procedure.

All non-physician first assistants are required to be privileged and have competency evaluated to be a surgical assistant if special surgical training has not been obtained.

Qualifications

1. Completion of a recognized program which provides knowledge of related didactic and clinical skills. Recognized programs include, but are not limited to:
   a. AORN First assistant certification program
   b. BOMEX Physician Assistant certification
   c. Surgical Assistant collegiate program
2. In lieu of a recognized program, certification by one of the following:
   a. American Board of Surgical Assistants
   b. National Surgical Assistant Association
   c. Association of Surgical Technologists (First assistant exam)
3. Tasks that maybe performed
   3. Preoperative evaluation, nursing assessment
   4. Writes preoperative orders, using existing protocols
   5. Assist with positioning and patient preparation
   6. Assist with or drape surgical field
   7. Assist with hemostasis
   8. Provide surgical field exposure
   9. Tissue handling
   10. Assist with maintaining a dry surgical field
   11. Assist with the identification of anatomical structures
   12. Assist with or perform wound closure
   13. Assists with or apply skin sutures
   14. Assist with volume replacement or autotransfusion techniques
   15. Assist with selection and application of appropriate wound dressings
   16. Assist in securing drainage systems to tissue
   17. Writes post-operative orders, using existing protocols

18. Participates in post-operative rounds
19. Assists with discharge planning
20. Special Procedures – as defined by the Supervising Physician (limited to PAFA, RNFA, NPFA) Inject the surgical site under the direct supervision of the sponsoring physician

ARTICLE VI: CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every member of the Medical Staff, an AHP or a First Assistant at Surgery providing clinical services at the Hospital by virtue of Medical Staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically granted to him by the Governing Board, except as provided in Sections 7.4 and 7.5 of this Article VII.

6.2 DELINEATION OF PRIVILIGES IN GENERAL

6.2.1 REQUESTS

Every application for appointment and reappointment must contain a request for the specific clinical or professional practice privileges desired by the applicant. Requests from an applicant for privileges, or from membership for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

6.3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI for members of the medical staff, and in Article V for AHP staff and first assistant at surgery if they differ from Article VI.

6.4 SPECIAL CONDITIONS APPLICABLE TO LIMITED LICENSE PRACTITIONERS

6.4.1 ADMISSIONS

Dentists, podiatrists, and psychologists who are members of the Associate Staff may co-admit patients with a fully licensed physician member of the Medical Staff. The MD/DO member shall conduct the admitting history and physical examination (except the portion related to dentistry, podiatry or psychology), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the lawful scope of the limited license practitioner's practice.

6.4.2 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of the Surgical Service or his or her designee.

6.4.3 MEDICAL APPRAISAL

All patients admitted for care in the Health Care Center by a dentist, podiatrist or psychologist shall be co-admitted by a fully licensed MD or DO member of the Medical Staff and shall receive the same basic medical appraisal as patients admitted to other services, and the fully licensed physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Whether a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based on medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate service (s).

6.5 TEMPORARY PRIVILEGES

1 The CEO or designee, in consultation with the department chair may grant a temporary appointment

a. To fulfill an important patient care need the following must be obtained

i. Verification of current, valid, non-limited license from then state of Iowa,

ii. Evidence of current competence

b. For a new appointment to the medical staff or for a current member of the medical staff requesting new privilege(s) the following must be obtained

i. Verification of current, valid, non-limited license from then state of Iowa

ii. Relevant training and experience

iii. Current competency

iv. Current NPDB/HIDPB obtained and evaluated

v. Malpractice coverage in accordance with the requirements established by the Governing Board

vi. Verification of education

vii. AMA Profile for physicians (MD/DO) and physician assistants

viii. AOA profile for osteopathic physicians

ix. Student Clearinghouse for all other professions

x. A complete application of a new applicant to the medical staff or a current member of the medical staff is requesting additional privilege(s) and is awaiting review and approval by the medical executive committee and/or the governing body

2 The applicant may be granted temporary privileges if he/she

a. Has submitted a complete application

b. Has no current or previously successful challenges to licensure or registration

c. Has not been subject to involuntary termination of medical staff membership at another organization

d. Has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges

e. Has no current federal sanctions.

3 Temporary privileges may not exceed 120 days

6.6 EMERGENCY PRIVILEGES

For the purposes of this section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death, and any delay in administering treatment would add to that danger. In the case of emergency, any practitioner, to the degree permitted by his license and regardless of service, or Medical Staff status, or clinical privileges, shall be permitted and assisted to do everything

possible to save the patient from such danger. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are not requested or denied, the patient shall be assigned to an appropriate member of the Medical Staff by the Chief of Staff or his designee.

6.7 DISASTER PRIVILEGES

If the Disaster Management Plan is activated and the Hospital is unable to manage immediate patient needs, the CEO/Chief of Staff may grant disaster privileges to Practitioners. The CEO/Chief of Staff is not required to grant privileges to any requestor. Such decisions are made on a case-by-case basis at his/her/her discretion.

1 Practitioners requesting Disaster Privileges must be able to identify themselves with any of the following:

   a. A current picture identification card from a health care organization that clearly identifies professional designation
   b. A current license to practice
   c. Primary source verification of licensure
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   e. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   f. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

2 Practitioners granted disaster privileges shall be issued a Hospital identification badge which shall identify the practitioner as a volunteer member granted disaster privileges. Disaster privileges are terminated when the CEO/Chief of Staff or notifies the Medical Staff Office who will notify the Practitioner that his/her/her services are no longer needed. Primary source verification of must be obtained within 72 for the following

   a. License
   b. NPDB and HIPDB
   c. Malpractice coverage

3 The Medical Staff via the Medical Executive Committee will oversee the professional practice of the individual granted disaster privileges, and the decision to extend said privileges beyond 72 hours.

4 Any individual identified in the organization's disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised at the sole discretion of the organization without a right to a hearing or an appeal

ARTICLE VII: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

7.1GENERAL PROCDEDURES

7.1-1 PREAPPLICATION REQUIREMENT

Only those practitioners who meet the basic criteria for medical staff or allied health professional staff membership and privileges set forth in these Bylaws shall be eligible to apply for staff appointment. Practitioners requesting applications for appointment will be sent a letter by the CEO outlining the basic criteria for eligibility and requiring the practitioner to provide proof that he meets those criteria. If the criteria are met, the practitioner will receive an application form and a summary of the application, hearing, and appeal provisions of the Bylaws. If the criteria are not met, the practitioner will be so notified. The procedural due process rights set forth in Article IV of these Bylaws shall not be available to practitioners who are determined to be ineligible to apply for appointment because they do not meet the basic criteria.

7.1-2 NATURE OF MEDICAL STAFF CONSIDERATION

The Medical Staff, through its designated services, committees, and officers, shall consider each application for appointment, reappointment, and clinical privileges, and each request for modification of Staff Membership category or Clinical privileges, utilizing the resources of the CEO and his staff to investigate and validate the contents of each application, before adopting and transmitting its recommendations to the Governing Board.

7.1-3 APPLICATION FOR APPOINTMENT CONTENT

All applications for appointment to the Medical Staff or the Allied Health Professional Staff shall be in writing, submitted on a form prescribed by the Medical Executive Committee and approved by the Governing Board, with all provisions completed (or an explanation of why answers are unavailable), and signed by the applicant. The application shall require detailed information including, but not limited to:

The applicant's professional qualifications, current clinical competency, Iowa licensure, current DEA registration, continuing medical education related to the clinical privileges to be exercised by the applicant, and successful completion of a course in advanced cardiac life support.

The names of at least three persons who hold a professional license, at least one of which is the same license as the applicant, who can provide adequate references based on their current knowledge of the applicant's professional qualifications, professional competence, character, training, experience and judgment.

Whether any action, including any investigation, has ever been undertaken whether it is still pending or complete, which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

Pursuant to Section 15.2 of these Bylaws, evidence of the applicant's professional liability insurance coverage with a company licensed or approved to do business in Iowa, together with information regarding any professional liability claims, complaints, or causes of action that have been lodged against him within the past five (5) years and the status or outcome of such matters.

As to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent or willful act or omission in rendering services within the past five (5) years.

Details of any prior or pending government agency proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions, with the past five (5) years.

The applicant's ability to carry out the responsibilities and prerogatives of the Medical Staff Membership category and perform the clinical privileges applied for with reasonable skill and without exposing the applicant to others to significant health or safety risks.

Certification of the applicant's agreement to terms and conditions set forth in Section 6.2-2 regarding the effect of the application.

An acknowledgment that the application has received and read (or has

Been given access to) the Medical Staff Bylaws Rules and Regulations, and that he agrees to be bound by the terms thereof, as they may be amended from time to time, if he is granted membership or clinical privileges, and to be bound by terms thereof, without regard to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of this application.

The applicant shall also identify the Staff category, clinical service and clinical privileges for which the applicant wishes to be considered.

7.1-4 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, each applicant thereby signifies his willingness to appear for interviews in regard to his application; authorizes the Hospital and its representatives or its designees to consult with members of medical staffs of other hospitals with which the application has been associated and with others who may have information bearing on his competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications, ability and willingness to work harmoniously with others, moral and ethical qualifications for membership, and physical, mental., and professional competence to carry out the requirements and prerogatives of the Medical Staff membership category and perform the privileges requested with reasonable skill and without exposing himself or others to significant health or safety risks, and directs individuals who have custody of such records and documents to permit inspection and/or copying; certifies that he will report any changes in the information submitted on the

application form, which may subsequently occur, to the Medical Executive Committee and the CEO; and releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Hospital concerning the applicant and all Hospital representatives for their acts performed in connection with evaluating the applicant and his credentials.

7.2 PROCESSING THE APPLICATION

7.2-1 APPLICANT'S BURDEN

In connection with all applications for appointment, reappointment, advancement, or transfer, the application shall have the burden of producing accurate and adequate information for an adequate evaluation of his qualifications and ability to perform the requirements and prerogatives of the membership category and privileges applied for with reasonable skill and safety, and for resolving any reasonable doubts about these matters. The applicant's failure to sustain this burden shall be deemed a voluntary withdrawal of the application. Failure to complete and update the application form, failure to provide requested information, or providing incomplete, false or misleading information, shall in and of itself constitute a basis for denial or revocation of Medical Staff appointment or reappointment.

7.2-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the CEO who shall in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. In accordance with Title IV of Public Law
96-660, the Health Care Quality Improvement Act of 1986 (HCQIA), as amended, the Hospital will query the National Practitioner Data Bank. The CEO shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six months after it was received by the CEA shall be deemed to have voluntarily withdrawn his application from consideration for Staff membership. Such an applicant's application may, therefore, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, have been resubmitted.

An application is considered complete when all primary source verification is complete, all references obtained and any questions for the applicant have been adequately answered. When collection and verification is accomplished, the CEO shall transmit the application and all supporting materials to the Chief of the Medical Staff for evaluation by the Chief of the Service in which the applicant seeks privileges and by the Medical Executive Committee.

7.3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within 30 days after receipt of the completed application and supporting documentation, the Medical Executive Committee shall review the application, the supporting documentation, and such other relevant information as may be available. The Medical Executive Committee may ask the applicant to appear for an interview or request further documentation. The Committee shall then forward to the CEO, for transmittal to the Governing Board, its written report and recommendations. The Committee may also defer action on the application pursuant to Section 6.3-6(a).

7.3-1 APPOINTMENT REPORTS

Medical Executive Committee report and recommendations shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify whether Medical Staff appointment is approval or denial of membership and privileges. If the recommendation is for approval, the membership category, service affiliation, and clinical privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

7.3-2 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Medical Staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications, can carry out the responsibilities, and meets all of the standard requirements set forth in all section of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements and prerogatives of staff membership and perform the clinical privileges applied for with reasonable skill and safety; his provision of accurate and adequate information to allow the Medical Staff to evaluate his competency and qualifications.

7.3-3 EFFECT OF MEDICAL EXECUTIVE COMMITTEE

1. <u>Interviews, Further Documentation, Deferral:</u> Action by the Medical Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within 60 days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for Medical Staff membership.

2. <u>Favorable Recommendation:</u> When the Medical Executive Committee's recommendation is favorable to the applicant, the CEO shall promptly forward it, together with all supporting documentation, to the Governing Board. For the purpose of this Section 6.3-6(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Service Chief and the Medical Executive Committee.

3. <u>Adverse Recommendation:</u> When the Medical Executive Committee's recommendation is adverse to the applicant, the Chief of Staff shall give the applicant written notice of the adverse recommendation to the Governing Board for consideration at its next regularly scheduled meeting noting the reason for the adverse recommendation. The Governing Board may delegate the review of such an application to a delegate committee of the Board. If any of these authorities makes any adverse recommendation, the application shall be denied.

4. The applicant's right to request a hearing in the manner specified in Section 9.3-2, and the applicant shall be entitled to the procedural rights as provided in Article IX.

7.4 ACTION BY THE GOVERNING BOARD

1. On Favorable Medical Executive Committee Recommendation: The Governing Board shall, in whole or in part, adopt or reject an Medical Executive Committee Recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting up a time limit within which a subsequent recommendation shall be made. If the recommendation of the Governing Board is one of those set forth in Section 9.2, the CEO shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IV before any final adverse action is taken.
2. Without Benefit of Medical Executive Committee Recommendation: If the Governing Board does not receive an Medical Executive Committee Recommendation within the time period specified in Section 6.3-12, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Board. If the recommendation is one of those set forth in Section 9.2, the CEO shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2, and the applicant shall be entitled to the procedural rights in Article IV before any final adverse action is taken.
3. After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Section 6.3-6 (c) or an adverse Governing Board recommendation pursuant to Section 6.3-79 (a) or (b), the Governing Board shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article IX. Action thus taken shall be the conclusive decision of the Governing Board, except that the Governing Board may defer final Determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time Limit within such a subsequent recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Governing Board shall make a final decision.

7.4-1 NOTICE OF FINAL DECISION

Notice of the Governing Board's final decision shall be given, through the CEO, to the Medical Executive Committee and the applicant.

A decision and notice to appoint shall include: (1) the staff category to which the applicant is appointed; (2) the clinical service to which he is assigned; (3) the clinical privileges he may exercise; and (4) any special conditions attached to the appointment.

7.5 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINGARY ACTION

An application who

Has received a final adverse decision regarding appointment or withdrew his application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or Governing Board;

A former medical staff member who has received a final adverse decision resulting in termination of medical staff membership and clinical privileges or resigned from the medical staff following the issuance of a medical staff or Governing Board recommendation adverse to the member's medical staff membership or privileges; or

A medical staff member who has received a final adverse decision resulting in Termination or restriction of his or her clinical privileges or denial of his request for additional clinical privileges, shall not be eligible to reapply for medical staff membership and/or clinical privileges affected by the previous action for a period of at least one year from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former medical staff member's resignation became effective, whichever is applicable.

A decision shall be considered to be adverse, for medical disciplinary reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse include actions based on a failure to maintain a practice in this area, which can be cured by a move, or to maintain professional liability insurance, which can be cured by securing such insurance. Further, for the purpose of this section, an adverse decision shall be considered final at the time of completion of:

All hearing and appellate review and other quasi-judicial proceedings conducted by the Hospital bearing on the decision and

All judicial proceedings bearing upon the decision which are filed and served after the completion of the Hospital proceedings described above.

After the one year period, the former applicant, former medical staff member, or medical staff member may request an application for medical staff membership and/or privileges, which shall be processed as an initial application. The former application, former medical staff member or medical staff member, shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or reasonable rehabilitation in those areas which form the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that he has complied with all of the specific requirements any such adverse decision may have included, such as completion or training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review by the Governing Board within 45 days after the Medical Executive Committee decision was rendered.

7.5-1 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all_individuals and groups, required by these Bylaws to act thereon and, except for good cause, shall be process within the time periods specified in this Section 6.3-10. The CEO shall transmit

the completed application to the Medical Executive Committee within 30 days after all information collection and verification tasks are completed and all relevant materials have been received. In the event that all relevant materials are not received within 60 days after the application is received by the CEO, the applicant shall be notified, and the application shall remain pending until either the materials are received by the CEO or the expiration of six months from the date the application was received. Applications which are not completed within six months after receipt shall automatically be removed from consideration. The Medical Executive Committee shall review the completed application and make a recommendation to the Governing Body at the next meeting of the Medical Executive Committee, not to exceed 60 days from the date they received the completed application. The Governing Body shall then take action on the application within 45 days, subject to any procedural rights to which the applicant may be entitled under these Bylaws. The time periods specified herein are assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his or her application processed within those periods.

7.6 REAPPOINTMENT

7.6-1 APPLICATION FOR REPAPPOINTMENT; SCHEDULE FOR REVIEW

At least sixty (60) days prior to the expiration of current appointment of a member of the Medical Staff or AHP Staff appointment, the CEO or designee shall mail a reappointment application to the Staff member.

At least forty-five (45) days prior to the expiration date of Staff appointment, each member of the Medical or AHP Staff shall submit to the CEO a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the Medical Staff and approved by the Governing Board, and it shall require detailed information concerning the changes in the applicant's qualifications since his last review. Specifically, the reappointment application form, as described in Section 6.2, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, whether the application requests any change in his Staff status and/or his privileges, Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privilege to be granted in an initial application for same.

7.6-2VERIFICATION OF INFORMATION

The CEO shall, in timely fashion, seek to collect or verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. In accordance with the HCQIA, as amended, the Hospital will query the National Practitioner Data Bank and Health Integrity Practitioner Data Bank as part of the reappointment process. The CEO shall transmit the completed reappointment application form and supporting materials to the Chief of the Medical Staff for evaluation by the Chief of each service in which the individual has or requests privileges and to the Medical Executive Committee.

7.6-3 MEDICAL EXECUTIVE COMMITTEE ACTION
The Medical Executive Committee shall review the completed application and supporting documents, the Service Chief's reports, and all other relevant information available to it, and shall forward to the Governing Board, through the CEO, its favorable reports and recommendations, prepared in accordance with Section 6.4-5.
When the Medical Executive Committee recommends adverse action as defined in Section 9.2, either in respect to reappointment or clinical privileges, the CEO shall give the application written notice of the adverse recommendation and of the application's right to request a hearing in the manner specified in Section 9.3-2, and the application shall be entitled to the procedural rights as provided in Article IX. The Governing Board shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his procedural rights.
Thereafter, the procedures specified in Sections 6.3-6 (Action by the Governing Board) and; 6.3-7 (Notice of Final Decision) shall be followed. The Committee may also defer action; however, any such deferral must be followed up within 60 days with a subsequent recommendation.
7.6-4 REAPPOINTMENT REPORTS
The Medical Executive Committee and Service Chief reports and recommendations shall be written and shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, service affiliation, and/or clinical privileges or terminated. Whether non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

7.6-5 BASIS FOR REAPPOINTMENT
Each recommendation concerning the reappointment of a practitioner or AHP and the clinical privileges to be granted upon reappointment shall be based upon whether such individual has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements application to the practice of his profession, with the medical Staff Bylaws and Rules and Regulations and Hospital policies; rendition of services to his or her patients; his ability to carry out the responsibilities and prerogatives of the membership category and perform the privileges requested with reasonable skill and safety; his provision of accurate and adequate information to allow the medical staff to evaluate his competence and qualifications; and information obtained from the National Practitioner Data Bank and other data sources as appropriate, and the representations set forth in the paragraph that follows.

By his application for membership and privileges, the practitioner makes the following representations:

That, to the best of his knowledge, the practitioner is not at risk of offset or other disallowance of future payments due under Medicare, Medicaid or other federal or state health programs, or other third party payment programs for professional services to be rendered, because of current or past billing, coding or documentation errors, or disputes

with a professional review organization. The practitioner agrees to make all reasonable attempts to ensure that patient signs and symptoms, and services rendered to patients, are appropriately documented, and agrees to cooperate with any compliance program or compliance audit that the Hospital may undertake to ensure that billing and coding for services rendered is conducted in full compliance with all laws and regulations.

That neither the practitioner nor his employees, contractors or agents, nor any member of the practitioner's immediate family, has or will have a "financial relationship" (as that term is defined in Section 1877 of the Social Security Act) with Hospital which fails to qualify for an exception to the prohibition contained therein against certain referrals of designated health services. For purposes of this provision, referrals of designated health services. For purposes of this provision, "immediate family" is defined to mean spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsisters, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild and spouse of a grandparent or grandchild. The practitioner shall immediately report to the Hospital's CEO or his designee, any known or suspected financial relationship to permit analysis to determine compliance with this provision.

That neither the practitioner nor any of his employees, contractors or agents, nor any member of the practitioner's household or immediate family, who now has or has had a direct or indirect ownership of 5% or more in the practitioner's professional practice, has ever been: assessed civil monetary penalties under the Social Security Act; debarred, suspended, or excluded from participating in either Medicare or Medicaid,; sanctioned under Medicare or Medicaid for reasons bearing on professional competence or professional performance; has ever had an ownership interest in any other organization which has ever had a civil monetary penalty under Medicare or Medicaid; or has ever been convicted or plead guilty or nolo contendere to any criminal violation which could cause a disqualification under applicable state law.

The practitioner agrees to immediately notify the Hospital of any threatened, proposed, or actual exclusion of the practitioner from participation in any governmental health care program.

7.6-6 FAILURE TO FILE REAPPOINTMENT APPLICATION
Failure to file an application for reappointment within the time period, and completed as required by Section 6.4-1, shall result in the automatic suspension of the practitioner's or AHP's privileges and prerogatives, unless otherwise extended by the Medical Executive Committee with the approval of the Governing Board. If the individual fails to submit an application for reappointment completed as required, on or before the expiration date of his appointment, he shall be deemed to have voluntarily resigned his membership in the Medical Staff or the Allied Health Professional Staff.

7.6-7 FAILURE TO REQUEST REINSTATEMENT
Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation form the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated, shall be entitled to the procedural rights provided in Article IX for the sole purpose of determining whether or not the failure to request reinstatement was

unintentional or excusable. A subsequent request for medical staff membership received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE VIII: CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 CRITERIA FOR INITIATION

Whenever a practitioner with clinical privileges shall engage in conduct, make statements, or exhibit demeanor either within or outside of the Hospital, and the same is, or is reasonably likely to be, detrimental to patient safety or the delivery or quality patient care within the Hospital, to be disruptive to Hospital operations or to constitute fraud or abuse, or the same results in the imposition of sanctions by any government authority, an investigation or corrective action against such practitioner may be requested by any officer of the Medical Staff, by the Chief of any Service in which the practitioner exercises clinical privileges, by the Chairman of any standing committee of the Medical Staff, by the Governing Board, or by the CEO, upon the complaint, request or suggestion of any person. Such acts, statements, demeanor or conduct by a Hospital employee or AHP should be brought to the attention of the CEO or Governing Board for their appropriate action.

8.1-2 PEER REVIEW PRIVILEGE AND CONFIDENTIALIITY

Corrective action and hearing and appellate review proceedings, as set forth in these Bylaws, shall be considered peer review committee proceedings entitled to the privilege and confidentiality protections of federal and state laws. The written request for investigation or corrective action, as well as complaint files, investigation files, reports, and other investigative information prepared for the purpose of the peer review matter at issue shall be considered peer review records that are privileged and confidential in the hands of the peer review committee and the Hospital, and shall be released only as required or permitted by law.

8.1-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by the Chief of Staff or Medical Executive Committee on its own initiative or by a written request which is submitted to the Chief of Staff or Medical Executive Committee, and must identify the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Chief of Staff shall promptly notify the CEO and Governing Board of all proposals for corrective action so initiated and shall continue to keep them fully informed of all action taken in conjunction therewith.

8.1-4 INVESTIGAITON

Upon receipt, the Chief of Staff or designee shall take action on the proposal or direct that an investigation be undertaken. The Chief of Staff may conduct that investigation himself or may assign this task to an appropriately charged officer, or standing or ad hoc

Medical Staff committee. No such investigative process shall be deemed to be a "hearing" as described in Article IX.

During the investigate process, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the investigating officer or body. At such interview, the practitioner shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of the interview shall be made and included in the report to the Medical Executive Committee.

If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Executive Committee, as soon as is practicable under the circumstances, but in any event within fifteen (15) days after the assignment to investigate has been made, unless extended for good cause shown. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Governing Board, terminate the investigative process and proceed with action as provided in Section 8.1-5 below.

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within forty-five (45) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.1-6 the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following recommendations:

1. No corrective action be taken and, if the Medical Executive Committee determines that no credible evidence existed from the complaint, the removal of any complaint-related information from the member's file.
2. Rejection or modification of the proposed corrective action.
3. Letters of admonition, censure, reprimand, or warning, be issued although nothing herein shall be deemed to preclude Service Chiefs from issuing informal written or oral warnings outside the corrective action mechanism. If such letters are issued the affected member may make a written response that shall be placed in the member's file.
4. Terms of probation or special limitations be imposed on continued membership or the exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
5. Reduction or revocation of clinical privileges.
6. Suspension of clinical privileges until completion of specific conditions or requirements.
7. Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

8. Suspension of Medical Staff membership until completion of specific conditions or requirements.
9. Revocation of Medical Staff membership.
10. Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2.

8.1-6 DEFERRAL

If additional time is need to complete the investigative process, the Medical Executive Committee may defer action on the request for a reasonable period of time, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1-5, Paragraphs (a) through (j) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within fifteen (15) days of the deferral.

8.1-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 8.1-5 which constitutes grounds for a hearing as set form in Section 9.2 shall entitle the affected practitioner to the procedural rights provided in Article IX of these Bylaws. In such cases, the CEO shall give the practitioner written notice of the adverse recommendation and of his right to request a hearing in the manner specified in Section 9.3-2.

8.1-8OTHER ACTION

1. If the Medical Executive Committee recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Governing Board, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-6 (Action by the Governing Board) and 6.3-7 (a) (Notice of Final Decision), as applicable.
2. If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant him an interview as provided in Section 8.4. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Governing Board without substantial modification, and notice of the final decision shall be given to the Governing Board, CEO, Medical Executive Committee, the Chief of each Service concerned, and the practitioner.
3. If any proposed corrective action by the Governing Board will substantially modify the Medical Executive Committee's recommendation, the Governing Board shall submit the matte rot the Joint Conference Committee for review and recommendation before making its decision final. Any recommendations of the Governing Board which constitutes grounds for a hearing as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the CEO shall give the practitioner written notice of the tentative

adverse recommendation and of his right to request a hearing in the manner specified in Section 9.3-2.

4. Should the Governing Board determine that the Medical Executive Committee has failed to act in timely fashion on the proposed corrective action, the Governing Board, after notifying the Medical Executive Committee, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the final decision of the Governing Board. If such action is one of these set forth in Section 9.2, the CEO shall give the practitioner written notice of the adverse recommendation and of his right to request a hearing in the manner specified in Section 9.3-2 and his rights shall be as provided in Article IX.

8.2 SUMMARY OF SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety to any patient, prospective patient, employee or other person present in the Hospital, any person or body authorized to initiate proposed corrective action pursuant to Section 8.1-1 hereof shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of the practitioner, and such summary suspension shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give oral or written notice of the suspension to the practitioner, Governing Board, Medical Executive Committee, and CEO. The notice of the suspension given to the Medical Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 8.1, shall be followed. In the event of any such suspension, the practitioner's patients whose treatment by such practitioner is terminated by the summary suspension shall be assigned to another practitioner by the Service Chief or by the Chief of Staff. The wishes of the patient shall be considered, where possible, in choosing a substitute practitioner.

8.2-2 EXECUTIVE COMMITEEE ACTION

A practitioner whose clinical privileges have been summarily suspended may request an interview with the Medical Executive Committee. As provided in Section 8.4, the interview shall be convened as soon as reasonably possible under all of the circumstances, ordinarily within 30 days of the date of the suspension. The Medical Executive Committee may thereafter recommend modification, continuance or termination of the terms of the summary suspension order, and written notice of its decision shall be given to the practitioner, the Governing Board, and the CEO.

8.2-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspension is terminated by the hearing Committee. The practitioner shall not be entitled to the procedural rights

afforded by Article IX until such time as the Medical Executive Committee or Governing Board has taken action pursuant to Sections 8.1-5 through 8.1-8, and then only if the action taken constitutes grounds for a hearing as set forth in Section 9.2.

8.3 AUTOMATIC SUSPENSION

8.3-1 LICENSE

1. Revocation or Expiration: Whenever a practitioner's or AHP's license authorizing him to practice in this state is revoked or has expired, his Staff membership, prerogatives and clinical privileges shall be immediately and automatically terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article IX.
2. Restriction: Whenever a practitioner's or AHP's license authorizing him to practice in this state is lifted or restricted by the applicable licensing authority, those clinical privileges which he has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.
3. Suspension: Whenever a practitioner's or AHP's license authorizing him to practice in this state is suspended, his Staff membership and clinical privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.
4. Probation: Whenever a practitioner or AHP is placed on probation by the applicable licensing authority, his applicable membership status, prerogatives, privileges, and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

8.3-2 DRUG ENFORCEMENT ADMINISTRATION

1. Revocation or Expiration: Whenever a practitioner's DEA certificate is revoked or has expired, he shall immediately and automatically be divested of his right to prescribe medications covered by this certificate.
2. Suspension: Whenever a practitioner's DEA certificate is suspended he shall be divested at a minimum, of his right to prescribe medications covered by the certificate effective upon, and for at least the term of, the suspension.
3. Restriction or Probation: Whenever a practitioner's DEA certificate is subject to restriction or an order of probation, his right to prescribe medications covered by the certificate shall automatically become subject to terms of the restriction or probation effective upon, and for at least the term of, the probation.

8.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails, without good cause, to appear and satisfy the requirements of Section 13.5-2, shall automatically be suspended from exercising all, or such portion of his clinical privileges as may be suspended, in accordance with the provisions of said Section 13.5-2.

8.3-4 MEDICAL EXECUTIVE COMMITTEE DELIBERTIONS ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, AND FAILURE TO SATISFY SPECIAL APPEARANCE

As soon as practicable after action is taken as described in Section 8.3-1, Paragraphs (b), (c), or (d) in Sections 8.3-2 or 8.3-3, the Medical Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it, and/or it may direct that an investigation be undertaken pursuant to Section 8.1-4. The procedure to be followed shall be as provided in Sections 8.1-7 and 8.1-8, as applicable, if the Medical Executive Committee takes action, or as described in Section 8.1-4 through 8.1-8 if the Medical Executive Committee directs a further investigation.

8.3-5 MEDICAL RECORDS

For failure to complete medical records within the time limits established by the Medical Staff Rules and Regulations and Hospital polices, a practitioner's clinical privileges (except with respect to his patients already in the Hospital) and his rights to admit patients and to provide any other professional services shall be automatically suspended upon the expiration of fourteen (14) days after he is given written notice of delinquency, and shall remain so suspended until all delinquent medical records are completed. A failure to complete the medical records within two (2) months after the date a suspension became effective pursuant to this section shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

8.3-6 PROFESSIONAL LIABILITY INSURANCE

For failure to maintain the amount of professional liability insurance required under Section 15.2, a practitioner's or AHP's membership and clinical or practice privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner or AHP provides evidence to the Medical Executive Committee that he has secured professional liability coverage in the amount required under Section 15.2. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

8.3-7 PROCEDURAL RIGHTS – MEDICAL RECORDS AND MALPRACTICE INSURANCE

Practitioners or AHP's whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of 8.3-5 (failure to complete medical records) or 8.3-6 (failure to maintain malpractice insurance) shall not be entitled to the procedural rights set forth in Article IX.

8.3-8 NOTICE OF AUTOMATIC SUSPENSION: TRANSFER OF PATIENTS

Whenever a practitioner's or AHP's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner or AHP, the Medical Executive Committee, the CEO and the Governing Board. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such practitioner is terminated by the automatic suspension, shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

8.3-9ENFORCEMENT
It shall be the mutual duty of the Chief of the Medical Staff, the CEO, and the Governing Board to cooperate fully in enforcing all automatic suspensions.

8.4 INTERVIEWS
Interviews shall neither constitute, nor be deemed, a "hearing", as described in Article IX; shall be preliminary in nature; and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant him an interview only when so specified in this Article VIII. In all other cases and when the Medical Executive Committee or the Governing Board has before it an adverse recommendation, as defined in Section 9.2, it may, but shall not be required to, furnish the practitioner an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE IX: HEARINGS AND APPELLATE REVIEWS

9.1 PREAMBLE AND DEFINITIONS

9.1-1 EXHAUSTION OF REMEDIES
If an adverse recommendation is made or action taken with respect to a practitioner's Staff membership, Staff status or clinical privileges at any time, regardless of whether he is an application or a Medical Staff member, he must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or assisting any claim against the Hospital or participants in the decision process.

9.1-2 DEFINITIONS
Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

1. "Body whose decision prompted the hearing" refers to the Medical Executive Committee or authorized officers, members, or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing before requested, and refers to Governing Board in all cases where the governing board or authorized officers, directors or committees of the Governing Board took the action or rendered the decision which resulted in a hearing being requested.
2. "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class, postage prepaid, certified, or registered mail, return receipt requested, addressed to the required addressee at his or its address as it appears in the records of the Hospital.

3. "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 9.3 of these Bylaws.
4. "Date of Receipt" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, of delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 9.1-2.

9.2 GROUNDS FOR HEARING

Any one or more of the following actions of recommended actions shall constitute grounds for a hearing:

1. Denial of Medical Staff membership.
2. Denial of requested advancement in staff membership status.
3. Denial of staff reappointment.
4. Demotion to lower staff category or membership status.
5. Suspension of staff membership until completion of specific conditions or requirements.
6. Summary suspension of staff membership during the pendency of corrective action and hearing and appeals procedures.
7. Expulsion form staff membership.
8. Denial of requested privileges (not including temporary privileges).
9. Reduction in privileges.
10. Suspension of privileges until completion of specific conditions or requirements.
11. Summary suspension of privileges during the pendency of corrective action and hearing and appeals procedures.
12. Termination of privileges (not including temporary privileges).
13. Requirement of consultation.

Recommendation of any of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

9.3 REQUEST FOR A HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases where the body which, under these Bylaws, has the authority to, and pursuant to that authority, has recommended or taken actions constituting grounds for hearing as set forth in Section 9.2 of this Article, said body shall, through the CEO give the affected practitioner notice of its recommendation, decision or action and notice of his right to request a hearing pursuant to Section 9.3-2 below.

9.3-2 REQUEST FOR HEARING

The petitioner shall have thirty (30) days following the date of receipt of such action to request a hearing by and ad hoc Hearing Committee. Said request shall be effected by notice to the Chief of Staff with a copy to the CEO. In the event the petitioner does not

request a hearing within the time and in the manner herein above set forth, he shall be deemed to have accepted the recommendation, decision or action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Board within forty-five (45) days, but shall not be binding on the Governing Board.

9.3.3 TIME AND PLACE FOR HEARING

Upon receiving a request for hearing, the Chief of Staff, within thirty (30) days after the date of receipt of the request, shall schedule and arrange for a hearing. He shall give notice to the petitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days form the date of receipt of the request for a hearing by the Chief of Staff; provided, however, that when the request is received from a petitioner who is under a suspension which is then in effect, and who is willing to waive the 30-day minimum notice requirement, the hearing shall be held as soon as arrangements may reasonably be made.

9.3-3 NOTICE OF CHARGES

As a part of, or together with the notice of hearing required by Section 9.3-3 above, the Chief of Staff, on behalf of the Medical Executive Committee, shall state in writing the acts or omissions with which the petitioner is charged, including a list of the charts being questioned or the grounds on which the application was denied, when applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing.

9.3-4 AD HOC HEARING COMMITTEE

When a hearing is requested, the Chief of Staff shall appoint an Ad Hoc Hearing Committee of the Medical Staff, or one or more independent practitioner reviewers as may be necessary or desirable under the circumstances. The members or independent practitioner (s) selected to serve on the Hearing Committee should not be actively participated in the formal consideration of the matter at any previous level and shall not be in direct economic competition with the practitioner requesting the hearing. When the practitioner requesting the hearing is a member of the Associate Staff, and the matter relates to the competency, of the practitioner, one member of the Hearing Committee shall be a licensed dentist, podiatrist, or psychologist, as appropriate. The Chief of Staff shall designate a Chairman who shall preside in the manner described in Sections 9.4-1 and 9.4-3 below, and handle all pre-hearing matters and preside until a hearing officer, as described in Section 9.4-4 is appointed. The Practitioner shall furnish the CEO within fifteen (15) days a list of witnesses expected to testify at the hearing on behalf of the Practitioner.

9.3-5 FAILURE TO APPEAR

Failure, without good cause, of the petitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved, and it shall thereupon become the final recommendation of the Medical Staff.

Such final recommendation shall be considered by the Governing Board within forty-five (45) days but shall not be binding on the Governing Board.

9.3-6 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by an affected person and shall be permitted by the Hearing Committee or its Chairman acting upon its behalf on a showing of good cause.

9.4 HEARING PROCEDURE

9.4-1 PRE-HEARING PROCEDURE

Each party shall promptly furnish to the other a written list of the names and addresses of the individuals, so far as then reasonably known or anticipated, who may give testimony in support of that party at the hearing. If witnesses are added after the list has been given to the other party, it shall be the duty of that party to notify the other of the change.

The failure to timely provide without good cause the names of a witness or witnesses shall prevent such witness or witnesses from appearing or testifying at the hearing. Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the hearing officer may confer with both parties to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing.

It shall be the duty of the member and Medical Executive Committee, or its designee, to exercise reasonable diligence in notifying the hearing officer of the Hearing Committee or any pending or anticipate procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

The Medical Executive Committee shall forward to the member a copy of and shall provide access to all evidence on which the charges or reasons are based or will be supported at the hearing.

9.4-2 REPRESENTATION

The practitioner, the Medical Executive Committee and the Governing Board may be represented at the hearing or the appellate review, provided the party desiring to be so represented shall give written notice to the other party and the Hearing Committee or Governing Board, as appropriate, at least fifteen (15) days prior to the commencement of the hearing. If the practitioner does not exercise the right to be represented by an attorney at law, the practitioner shall be entitled to be accompanied only by a physician, dentist, podiatrist, or psychologist licensed to practice in the State of Iowa, who preferably is a member in good standing of the Medical Staff. The body whose decision prompted the hearing shall appoint a representative from its membership, who shall present its recommendation, decision, or action taken and the materials in support thereof and examine witnesses. The foregoing shall not be deemed to deprive any party to its right to the assistance of legal counsel in preparing for the hearing or appellate review.

9.4-3 THE PRESIDING OFFICER

The Presiding Officer at the hearing shall be a hearing officer as described in Section 9.4-4 or, if no such hearing officer has been appointed, the Chairman of the Hearing Committee. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.

9.4-4 THE HEARING OFFICER

At the request of the petitioner, the Medical Executive Committee, the Hearing Committee, the Governing Board, the CEO, or his designee may appoint a hearing officer to preside at the hearing. The hearing officer preferably has experience in Medical Staff matters and may not be an attorney. He may not act as a prosecuting officer, or an advocate for the Hospital, Governing Board, Medical Executive Committee, the body whose action prompted the hearing, or the petitioner. If the hearing officer is an attorney, he may be requested by the Hearing Committee to participate in the deliberations of such body and be a legal advisor to it, but he shall not be entitled to vote.

9.4-5 RECORD OF THE HEARING

The Hearing Committee shall maintain a record of the hearing by one of the following methods: a certified shorthand reported present to make a record of the hearing, or a recording of the proceedings. The cost of any certified shorthand reporter shall be borne equally by both parties. The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this state or by affirmation under penalty of perjury to the Presiding Officer.

9.4-6 RIGHTS OF THE PARTIES

A hearing, both sides shall have the following rights: to ask Hearing Committee members questions which are directly related to determining whether they are impermissibly biased and to challenge such members; to call and examine witnesses; to introduce exhibits or other documents; to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues; and otherwise to rebut any evidence. The petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one of more members of the committee shall be resolved by the committee prior to the continuation of the proceedings.

9.4-7 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including

hearsay, shall be admitted by the Presiding Officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his position and the Hearing Committee may request such a statement be filed following the conclusion of the presentation of oral testimony. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

9.4-8 BASIS OF DECISION
If the Hearing Committee should find the charge (s), or any of them, to be true, it shall impose such form of discipline as it shall find warranted, including such form of discipline or action that may be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

1. oral testimony of witnesses.
2. briefs or written statements presented in connection with the hearing.
3. any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.
4. any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
5. any other evidence admissible hereunder.

9.4-9 BURDEN OF GOING FORWARD AND BURDEN OF PROOF
At any hearing involving any of the grounds for hearing specified in Subsections (a), (b), or (h) of Section 9.2., it shall be incumbent upon the petitioner initially to come forward with evidence of support of his position. In all other cases, the body whose decision prompted the hearing shall have the duty, initially, to come forward with evidence in support of such decision; thereafter, the burden shall shift to the petitioner to produce evidence in support of his position.

Subject to the foregoing, the petitioner shall bear the ultimate burden of persuading the Hearing Committee, by a preponderance of the evidence provided at the hearing, that the reasons for the decision, assigned by the body whose decision prompted the hearing, lacked foundation in fact or that the action or decision recommended by the body whose decision prompted the hearing was otherwise arbitrary or unreasonable.

9.4-10 ADJOURMENT AND CONCLUSION
The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Committee shall thereupon, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying a report.

9.4-10 DECISION OF THE HEARING COMMITTEE
Within fifteen (15) days after final adjournment of the hearing (provided that in the event the petitioner currently under suspension, this time shall be ten (10) days, the Hearing Committee shall render a decision which shall be accompanied by a written report that contains findings of fact, which shall be in sufficient detail to enable the parties, any appellate review board, and the Governing Board to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered to the Medical Executive Committee, the CEO, and the Governing Board. At the same time, a copy of the report and decision shall be delivered to the petitioner by registered or certified mail, return receipt requested. The decision of the Hearing Committee shall be considered final, subject only to right of appeal to the Governing Board as provided in Section 9.5.

9.5 APPEALS TO THE GOVERNING BODY

9.5-1 TIME FOR APPEAL
Within 30 days after the date of receipt of the Hearing Committee decision, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the Governing Board. Said request shall be delivered to the CEO in writing either in person or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reason for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Board within forty-five (45) days, but shall not be binding on the Governing Board.

9.5-2 GROUNDS FOR APPEAL
The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

1. substantial noncompliance with the procedures required by these Bylaws or applicable law so as to deny a fair hearing.
2. the decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to Section 9.5-5; or
3. action taken arbitrarily, unreasonably, or capriciously.

9.4-3 TIME, PLACE AND NOTICE
When appellate review is requested pursuant to the preceding subsection, the Governing Board shall, within thirty (30) days after the date of receipt of such an appeal notice, schedule and arrange for an appellant review. The Governing Board shall give the petitioner notice of the time, place and date of the appellate review. The date of appellate review shall not be less than fifteen (15) days nor more than sixth (60) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not

to exceed thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Governing Board or appeal board (if any).

9.5-4 APPEAL BOARD

When an appellate review is requested, the Governing Board may sit as the appeal board or it may appoint an appeal board which shall be composed of Governing Board members and shall have at least three (3) members. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter. Upon request by the affected practitioner, the meeting of the Governing Body may be closed in order to avoid needless and irreparable injury to the practitioner's reputation.

9.5-5 HEARING PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Hearing Committee hearing; or the appeal board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral argument. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. If an appeal board is appointed, the appeal board shall present to the Governing Board its written recommendations as to whether the Governing Board should affirm, modify, or reverse the Hearing Committee for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to a hearing before the Governing Board.

9.5-6 DECISION

Within fifteen (15) days after the conclusion of the appellate review proceedings, the Governing Board shall render a final decision in writing. The Governing Board may affirm, modify or reverse the Hearing Committee decision or, in its discretion, remand the matter for further review and recommendation by the Hearing Committee or any other body or person. Copies of the decision shall be delivered to the petitioner and to the Medical Executive Committee, by personal delivery or by certified or register mail, return receipt requested. If the decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If the decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Board shall refer the matter to the Joint Conference Committee for further review and

recommendation, and shall include in such notice of its decision a statement that a final decision will not be made until the recommendation of the Joint Conference Committee have been considered.

9.5-7 FURTHER REVIEW

Except when the matter is remanded for further review and recommendation pursuant to Section 9.5-6, the final decision of the Governing Board following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. However, if it remanded to the Hearing Committee or any other body or person, said committee, body, or person shall promptly conduct its review and make is recommendations to the Governing Board in accordance with the instructions given by the Governing Board. This further review process and the time required to report back shall in no event exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

9.5-8 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of either the Medical Executive Committee or the Governing Board or by both.

9.5-9 REPORTING

Final disciplinary action approved by the Governing Board, that results in a limitation, suspension, or revocation of a practitioner's privileges to practice, or any voluntary surrender or limitation of privileges, for reasons relating to professional competence or professional conduct shall be reported to all appropriate authorities by the CEO, in accordance with the requirements of federal and state laws.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS, MEDICO-ADMINISTRATIVE OFFICERS AND CONTRACT STAFF.

1. Closed Staff or Exclusive Use Departments. The fair hearing rights of Articles VIII and IX do not apply to a practitioner whose application for Medical Staff membership and privileges was denied on the basis the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his position to the Governing Board.
2. Medico-Administrative Officers and Contract Staff. The fair hearing rights of Articles VIII and IX do not apply to those persons serving the Hospital in a contract or medico-administrative capacity. Such persons shall instead be governed by the provisions of these bylaws specific to contract staff and medico-administrative officers and by the terms of their individual contracts and

agreements with the Hospital. However, the hearing rights of the preceding sections of this Article IX and of Article VIII shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative rights applicable to such decisions.

9.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.3-1(a). In other cases described in Section 8.3-1 and 8.3-2, the issues which may be considered at hearing, if requested, shall include evidence concerning whether the member may continue to practice in the Hospital with those limitations imposed, not whether the determination by the licensing or credentialing authority or the DEA was unwarranted.

ARTICLE X: OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The officers of the Medical Staff shall be:

1. Chief of Staff (President)
2. Vice President
3. Secretary/Treasurer

10.1-2 QUALIFICATIONS

Officers must be physician members (M.D's and D.O's) in good standing of the Active Medical Staff and shall have been so far at least one (1) year at the time of nomination and election, and must remain members in good standing during their term of office. A member "in good standing" is one whose privileges to admit and provide services to patients have not been restricted. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 NOMINATIONS

The Medical Staff Executive Committee is a rotational basis of the Active Medical Staff with each member serving a three year term. As members join the Medical Executive Committee, the first year they serve as Secretary/Treasurer, followed by Vice President the second year and as Chief of Staff/President the third year

10.1-4 – CONFIRMATION OF OFFICERS (changed from Election)

Officers shall be confirmed at the annual meeting of the Medical Staff in January.

10.1- 5 - TERM OF OFFICE
All officers shall serve a one-(1) year term commencing on the first day of the Medical Staff year following their election. Each officer shall serve until the end of the term and until a successor is elected, unless he shall sooner resign or be removed from office.

10.1-6 REMOVAL OF ELECTED OFFICERS AND MEMBER OF THE MEDICAL EXECUTIVE COMMITTEE
Except as otherwise provided in these Bylaws, removal of an officer may be initiated by the Medical Executive Committee or upon the written request of twenty percent (20%) of the members eligible to vote for officers. Such removal may be effected by a majority vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article X, Section 15.9. The written ballots shall be sent to each voting member at least ten (10) days before the voting date and the ballots shall be counted by the Secretary/Treasurer (except when he is the subject of the balloting, in which case the Chief of Staff shall count the ballots) and the CEO. Removal shall be effective upon the approval of the Hospital Governing Board.

1. Indications for removal of a medical staff officer include
    a. Attendance issues
    b. Criminal activity
    c. Dereliction of responsibilities
    d. Discriminatory activities
    e. Failure to adequately represent the medical staff before the hospital's administrative bodies
    f. Felony convictions
    g. Loss of license to practice
    h. Loss of medical staff membership
    i. Misuse or abuse of authority and position
    j. Negligence or malfeasance
    k. Non-adherence to professional standards of conduct
    l. Non-adherence to the provision of quality standards of care
    m. Performance and competency issues
2. Removal for cause and disciplinary actions that could result in termination include but are not limited to
    a. Sexual harassment
    b. Substance abuse, including performing duties under the influence
    c. Violation of compliance regulations
    d. Violation of organizational policies, procedures, and safety standards

e. Willful disregards of Medical Staff Bylaws, Rules and Regulations, policies, protocols of the organization

10.17 Vacancies in office shall be filled by appointment by the Medical Executive Committee at a regular or special meeting until the next Medical Executive Year

10.2 DUTIES OF OFFICERS

10.2-1 CHIEF OF STAFF (PRESIDENT)

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

1. Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;
2. Shall, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
3. Serve as Chairman of the Medical Executive Committee;
4. Serve as an ex officio member of all other Medical Staff committees without vote unless his membership in a particular committee is required by these Bylaws;
5. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated, and for the Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
6. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees, except the Medical Executive Committee;
7. Be the spokesman for the Medical Staff in its external professional and public relations;
8. Shall serve as a liaison representative between the Medical Staff and Governing Board representing the views, polices, needs and grievances of the Medical Staff to the Governing Board and to the CEO, and interpreting the policies of the Governing Board to the Medical Staff; and
9. Perform such other functions as may be assigned to him by these Bylaws, by the membership, by the Medical Executive Committee, or by the Governing Board.

10.2-2 VICE PRESIDENT

In the absence of the Chief of Staff, the Vice-President shall assume all duties and the authority of the Chief of Staff. The Vice President shall be a member of the Medical Executive Committee and the Joint Conference Committee, shall perform such other supervisory duties as the Chief of Staff may assign and shall carry out such other functions as may be delegated to him by these Bylaws by the membership, by the Medical Executive Committee or by the Governing Board.

10.2-3 SECRETARY/TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The Secretary/Treasurer shall:

1. Maintain a roster of members;
2. Assure accurate and complete minutes of all medical executive committee and medical staff meetings;
3. Call meetings on the order of the chief of staff or medical executive committee;

4. Assure all appropriate correspondence and notices on behalf of the medical staff;
5. Receive and safeguard all funds of the medical staff;
6. Perform such other duties as ordinarily pertain to the office or are assigned by the chief of staff of medical executive committee.

ARTICLE XI: CLINICAL SERVCES

11.1 ORGANIZATION OF SERVICES

There shall be Services of Medicine-: Surgery-Anesthesia; Radiology-Nuclear Medicine; Ultrasound and CT; Pathology/Clinical Laboratory; Emergency; Nursing Facility; and such other Services as may be warranted. Each Service may be headed by the Chief of Service or may function under the Medical Executive Committee.

11.2 SERVICE CHIEFS

11.2-1 QUALIFICATIONS

Each Chief shall be a member of the Active Staff and a member of the Service which he is to head, shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the Service, shall be willing and able to discharge the administrative responsibilities of his office. Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process

11.2-2 SELECTION

Each Chief shall be appointed by the Chief of Staff; subject to the approval of the Medical Executive Committee and the Governing Board.

11.2-3 TERM OF OFFICE

Each Chief shall serve a one-year term, commencing on his appointment. He shall serve until the end of the succeeding Medical Staff year and until his successor is chosen, unless he shall sooner resign or be removed from office. A Chief may be removed by a majority vote of the Governing Board or of the Medical Executive Committee with the approval of the Governing Board.

11.2-4 DUTIES

Each Chief shall:

1. Clinically related activities of the department
2. Administratively related activities of the department, unless otherwise provided by the hospital
3. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
5. Recommending clinical privileges for each member of the department
6. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
7. Integration of the department or service into the primary functions of the organization

8. Coordination and integration of interdepartmental and intradepartmental services
9. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
10. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
11. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
12. Continuous assessment and improvement of the quality of care, treatment, and services
13. Maintenance of quality control programs, as appropriate
14. Orientation and continuing education of all persons in the department or service
15. Recommending space and other resources needed by the department or service
16. be accountable to the Medical Executive Committee for all the effective operation of his Service;
17. develop and implement programs to carry out the quality review, evaluation and monitoring functions assigned to his Service, and report regularly thereon to the Medical Executive Committee.
18. exercise general supervision over all clinical work performed within his Service;
19. be responsible for implementation within his Service or actions taken by the Medical Executive Committee or the Medical Staff;
20. conduct investigations and submit reports and recommendations to the Medical Executive Committee concerning the appointment or reappointment and the clinical privileges to be exercised by all practitioners and AHP's applying for or practicing in his Service;
21. assist in the teaching, education and research program in his Service;
22. act as Presiding Officer at all Service Meetings;
23. assist in the preparation of such annual reports; including budgetary planning, pertaining to his Service as may be required by the Medical Executive Committee; CEO, or the Governing Board; and
24. perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Chief of Staff; the Medical Executive Committee, or the Governing Board.

11.3 FUNCTIONS OF SERVICES

a. Assure that patient care reviews are conducted for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients within the Service. The number of such reviews to be conducted during the year shall be conducted in accordance with such procedures as may be adopted by the Quality Assurance Committee. Each Service shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of action which has been taken in such problems. The Medical Executive Committee may assign certain case review responsibilities, such as surgical cases and tissue review, to the Quality Assurance Committee.

b. Submit reports to the Medical Executive Committee and Medical Staff concerning: 1) findings of the Service's review, evaluation and monitoring activities, acts taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Service in the Hospital. If such reports are oral, a written summary of the oral report shall be prepared.

c. Assist in establishing guidelines for the granting of clinical privileges within the Service and submit the recommendations required under Articles VI and VII regarding the clinical privileges each member or applicant should be authorized to exercise.

d. Conduct or participate in, and make recommendations regarding the need for continuing education program pertinent to changes in the state-of-the-art and regarding findings of review, evaluation, and monitoring activities.

e. Monitor, on a continuing and concurrent basis, adherence to: (1) Medical Staff and Hospital policies and procedures; (2) requirements for alternate coverage and for consultations: (3) sound principles of clinical practice and (4) fire and other regulations designed to promote patient safety.

f. Coordinate the patient care provided by the Service's members with Nursing and Ancillary Patient Care Services and with Administrative Support Services.

g. establish such committees and other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

11.4 ASSIGNMENT OF SERVICES

Each practitioner and AHP shall be assigned membership in at least one Service, but may be granted membership and/or clinical privileges in one or more of the other Services. The exercise or privileges within each Service shall be subject to the Rules and Regulations thereof.

ARTICLE XII: COMMITTEES

12.1 GENERAL

The Committees described in this Article shall be the Standing Committees of the Medical Staff. Unless otherwise specified, the members of such Committees and Chairman of such Committees shall be appointed by the Chief of Staff and such Committees shall be responsible to the Medical Staff. Unless membership on a Committee is otherwise specified in these Bylaws, the Chief of Staff may appoint representatives of Hospital Management, Nursing Service, Medical Records, Pharmacy and other Hospital departments or services as may be necessary or desirable. The CEO may attend any meeting of any medical staff committees at the discretion of the committee chair, the Governing Board, or the CEO, unless his membership on a committee is expressly required in these Bylaws. Unless otherwise specified, the CEO's participation shall be an ex officio without vote.

In addition, Special Committees may be created by the Chief of Staff with the approval of the Medical Staff on an ad hoc basis to perform specified tasks. Such Committee shall

terminate at the end of the Medical Staff year unless they are renewed by the Medical Executive Committee. The members of special Committees shall also be appointed by the Chief of Staff, subject to the approval of the Medical Staff.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

(a) a named Committee, but no such Committee shall exist, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the functions of such Committee to a new or existing Committee of the Medical Staff or to the Staff as a whole.

(b) the Medical Executive Committee, but a standing or special Committee has been formed to perform the function, the Committee so formed shall act in accordance with the authority delegated to it.

The functions of any committee, except for the peer review and credentialing functions of the Medical Executive Committee, may be carried out by the Medical Staff as a whole.

12.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a Committee member shall be appointed for a term of one year, and shall serve until the end of this period and until his successor is appointed, unless he shall sooner resign or be removed from the Committee. Any Committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Staff. The removal of any Committee member who is automatically assigned to a Committee because he is a general officer or medical administrative officer shall be governed by the provisions pertaining to removal of such officers.

12.1-3 VACANCIES

Unless otherwise specified, vacancies on any Committee shall be filled in the same manner in which an original appointment to such Committee is made.

12.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article XIII.

12.1-5 VOTING

Unless otherwise specified, the only voting members of the medical staff committees shall be members of the medical staff.

12.1-6 PRIVILEGE AND CONFIDENTIALITY

Any and all activities undertaken by any Committee for the purpose of achieving and maintaining quality patient care, evaluating the competency of a practitioner, or reducing morbidity and mortality, and all data, documents, reports, and records related thereto, shall be privileged and confidential pursuant to federal and state laws.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2-1 COMPOSITION

The Medical Executive Committee shall consist of the officers of the Medical Staff, namely the Chief of Staff (President), Vice-President, and Secretary/Treasurer. The CEO of the Hospital shall be an ex officio member, without voting privileges. At least two members of the Governing board who all be appointed by the Governing Board Chairman, will serve as ex-officio members without voting privileges.

12.2-2 DUTIES

The Medical Executive Committee is delegated the primary authority over activities related to the functions of self-governance of the Medical Staff and over activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges.

The duties of the Medical Executive Committee shall be to:

1. Represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
2. Coordinate the activities and general polices of the Medical Staff not otherwise established as the responsibility of the Services;
3. Receive and act upon Service and Committee reports;
4. Implement policies of the Medical Staff not otherwise the responsibility of the Services;
5. Review and approve changes to the Medical Staff Bylaws as necessary until the next regularly scheduled Medical Staff Meeting. At that time, such bylaw changes shall be brought to the Medical Staff for vote and final approval in accordance with the Bylaw change procedure outlined in these Bylaws.
6. Recommend action to the CEO on matters of a medico-administrative nature;
7. Fulfill the Medical Staff's accountability to the Governing Board for the medical care rendered to patients in the Hospital;
8. Review the credentials of applicants and to make recommendations for Staff membership, assignment to Services, and delineation of clinical privileges;
9. Review periodically all information available regarding the performance
10. And clinical competence of Staff members, other practitioners and AHP's with clinical privileges and, as a result of such reviews, make recommendations for reappointments and renewals or changes in clinical or practice privileges;
11. Take all reasonable steps to ensure professionally ethical conduct on the part of all practitioners and AHP's, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
12. Report at each general Staff meeting;
13. To act on the medical staff's behalf between meetings of the medical staff;
14. Perform such other functions as may be assigned to it by these Bylaws, by the Medical Staff or by the Governing Board; and
15. Conduct an annual review of the Bylaws, Rules and Regulations of the Medical Staff; receive comments and recommendations regarding these matters from the Medical Staff; the Chief of Staff, the Services, the Governing Board and the CEO; and submit

recommendations to the Medical Staff and the Governing Board for changes in these documents.

12.2-3 MEETINGS
The Medical Executive Committee shall meet once a month or as needed, and shall maintain a record of its proceedings and actions.

12.3 QUALITY IMPROVEMENT COMMITTEE

12.3-1 COMPOSITION
The Quality Improvement Committee shall consist of at least one (1) physician appointed by the Chief of Staff, the CEO or his designee and the Quality Improvement Coordinator or designee. Attendance of other Hospital Representatives may be requested when considered necessary or desirable.

12.3-2 DUTIES
The Committee Shall:

1. Adopt, subject to Medical Staff and Governing Board approval, a quality improvement plan which sets forth specific programs and procedures for reviewing, evaluating and improving the quality and efficiency of patient care within the Hospital on a Hospital-wide basis. The plan may include mechanisms for:
   a. establishing objective criteria;
   b. measuring actual practice against the criteria;
   c. analyzing practice variations from criteria by peers;
   d. taking appropriate action to correct identified problems;
   e. following up on action taken; and
   f. Reporting the findings and results of The Quality Improvement Plan shall be considered as part of the Bylaws Rules and Regulations of the Staff.

12.3-3 MEETINGS
This Committee shall conduct or cause QI activities to be conducted and reviewed at least monthly, and shall meet as needed but no less frequently than quarterly. It shall maintain a record of its proceedings and activities, and shall report thereon to the Medical Staff and Governing Board.

12.4 SAFETY COMMITTEE
12.4-1 COMPOSITION
The Safety Committee shall include one (1) physician liaison as appointed by the Chief of Staff, the CEO or designee, Quality Improvement Coordinator, Nursing Administration, Nursing Management, Plant Services, Diagnostic Services Manager, Human Resources Director. Attendance of other Hospital Representatives may be requested when considered necessary or desirable.

12.4-2 DUTIES
The committee shall:

1. Develop and periodically review policies and procedures relating to patient, employee, visitor, volunteer, student or others safety within the Hospital.

2. Develop and maintain methods for and the protection and care of patients and others at time of internal and external disaster. Specifically, it shall:
   a. Adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least four times a year.
   b. Adopt and periodically review a plan for the care, reception and evacuation during a disaster event, and shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, community services, and the anticipated role of the Hospital in the event of disasters in nearby communities. The plan is reviewed by all personnel annually and is rehearsed at least twice per year either by an actual event or drill.

12.5 INFECTION CONTROL COMMITTEE

12.5-1 COMPOSITION

The Infection Control Committee shall consist of at least one member of the Medical Staff, Pathology, Nursing Management representatives, Director of Diagnostic Services, Plant Services or housekeeping, Laboratory and the QI Coordinator. Attendance of other Hospital representatives may be requested when considered necessary or desirable.

12.5-2 DUTIES

1. Develop a Hospital-wide infection control program and maintain a surveillance program.
2. Develop a system for reporting, identifying and analyzing the incidence and cause of all hospital acquired infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
3. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluation aseptic isolation and sanitation techniques. Such techniques shall be defined in written policies and procedures.
4. Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of polices and quality of care administered.
5. Develop, evaluate and review preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities including: operating rooms, central service, dietetic service, housekeeping, maintenance and laundry, isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment, ambulatory care services, testing of Hospital personnel for carrier status, disposal of infectious material, food sanitation, waste management, and other situations as requested.
6. Act upon recommendations related to infection control from the CEO, the Medical Executive Committee, the services and other Medical Staff and Hospital committees.

12.5-3 MEETINGS

This Committee shall meet no less than quarterly. It shall maintain a record of its proceedings and activities, and shall report thereon to the Medical Staff and Governing Board.

12.6 UTILILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

12.6-1 COMPOSITION

The Committee shall consist of at least one member of the Medical Staff, Chief Nursing Officer, Patient Outcomes Coordinator, UR Coordinator, Health Information Management Manager and the QI Coordinator. Others may be invited to attend when considered necessary or desirable.

12.6-2 DUTIES

The Committee shall:

1. Conduct utilization review designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay and discharge practices. This review may be done on a sample basis. The Committee shall communicate the results and other pertinent data to the entire Medical Staff and shall make recommendations for the utilization of Hospital resources and facilities commensurate with quality patient care and safety.
2. Evaluate the professional services furnished including drugs and biologicals
3. Formulate a written utilization review plan for the Hospital. Such plan, which shall be approved by the Medical Staff and the Governing Board.
4. Evaluate the medical necessity and appropriateness for continued Hospital stay for patients. The Committee shall be guided by the following criteria:
    a. No physician shall have review responsibility for any extended stay cases in which he was professionally involved.
    b. All decisions that further inpatient stay is not medically necessary shall be made by physician members of the Committee and only after opportunity for consultation has been given the attending physician by the Committee and full consideration has been given to the availability of out-of-hospital facilities and services.
    c. Where there is significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital Services for the patient, the judgment of the attending physician shall be given great weight.
5. All decisions that further inpatient stay is not medically necessary shall be given written notice to the Medical Executive Committee, to the Chief of the appropriate Service, to the CEO, and to the attending physician for such action, if any, as may be warranted.
6. Prepare a report as part of the Hospital's annual evaluation on the appropriateness of utilization of services.
7. Submit reports to the Medical Staff on the overall quality and efficiency of medical care provided in the hospital, on the Service Committees, patient care audit, utilization review and other quality review, evaluation and monitoring activities.
8. Review Medical Staff and Hospital Polices and Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein.
9. Antibiotic Usage Review: Ongoing review of prophylactic and therapeutic use of antibiotics for inpatient and emergency patients. Criteria for use in problem areas shall be established and deviations reviewed.

12.6-3 MEETINGS
The Committee shall meet at least quarterly and more frequently as needed to review the activities and findings of the staff, and shall maintain a record of its proceedings and actions.

12.7 PHARMACY AND THERAPEUTICS/MED SURG COMMITTEE

12.7-1 COMPOSITION
Membership shall consist of at least one representative of the Medical Staff and one each from the Pharmaceutical Service, Nursing Service, and Administration.

12.7-2 DUTIES
This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs. It shall also perform the following specific functions:

1. Serve as an advisory group to the Medical Staff and the pharmacist on matters pertaining to choice of available drugs.
2. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
3. Develop and review periodically a formulary or drug list for use in the Hospital.
4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.
5. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
6. Review and report on all medication errors and adverse drug reactions
7. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
8. Address all medication recalls
9. Report on the process for managing high-alert medications with dosing limits, administration guidelines, packaging, labeling and storage;
10. Approval of power plans and protocols

12.7-3 MEETINGS
This Committee shall meet at least quarterly and provide reports to the Medical Staff regarding its activities. If such reports are oral, a written summary of the report shall be prepared.

12.8 AMBULANCE/ED/TRAUMA/CARDIOPULMONARY/RADIOLOGY COMMITTEE

12.8-1 COMPOSITION
Membership shall consist of the Medical Staff representing the Emergency Services, including trauma care, Diagnostic Services Manager, Nursing Management, and staff

representation from Ambulance and Emergency Room. Others may be invited to attend when considered necessary or desirable.

12.8-2 DUTIES

This Committee shall be responsible all of the following functions:

1. Formulate and update existing policies and procedures for the Emergency Service and enforce existing policies; define and delineate responsibility for Emergency Service functions, and appraise the services rendered; receive reports from the Medical Director of the ambulance service and prepare and submit quarterly evaluations of the emergency and ambulance services to the Medical Staff Committee.
2. Approval of power plans and protocols.
3. Review of resuscitation and trauma events.

12.8-3 MEETINGS

This Committee shall meet at least quarterly and provide reports to the Medical Staff regarding its activities. If such reports are oral, a written summary of the report shall be prepared.

12.9 SURGERY/ANESTHESIA/TISSUE & TRANSFUSION COMMITTEE

12.9-1 COMPOSITION

Membership shall consist of at least one representative of the Medical Staff and one each from the following departments: Nursing Administration, Nursing Management, Anesthesia and Pathology. Other representation may include OR and General Surgery Clinic staff. Others may be invited to attend when considered necessary or desirable.

12.9-2 DUTIES

This Committee shall be responsible for all of the following:

1. Develop a screening mechanism based on predetermined criteria for those cases involving no specimen.
2. monitor and evaluate the following functions:
    a. Blood Utilization Review: Quarterly review of blood transfusions for proper utilization, to include the use of whole blood vs. components, evaluation and reporting of each actual or suspected reaction, and review of the amount of blood requested, the amount used and the amount of wastage.
    b. Anesthesia Review: Ongoing responsibility for monitoring the quality of anesthesia care rendered by practitioners in the surgical areas and developing regulations covering anesthesia safety.
    c. Surgical Case Review: Monthly review of all surgical matters, which shall include a comprehensive review for justifiability of all surgery performed whether tissue was removed or not, for acceptability of the procedure chosen and for agreement or disagreement between the preoperative, postoperative, and pathological diagnosis. Such review shall be undertaken for the purpose of reducing morbidity and mortality, and all data, documents, reports, and records related thereto shall be strictly confidential. Quarterly evaluations of

anesthesia and surgical services shall be submitted to the Medical Executive Committee.

12.9-3 MEETINGS
This Committee shall meet at least quarterly and provide reports to the Medical Staff regarding its activities. If such reports are oral, a written summary of the report shall be prepared.

12.10 REHAB SERVICES

12.10-1 COMPOSITION
Membership shall consist of at least one representative of the Medical Staff and the Rehab Services Manager. Other members include Nursing Management and the Cardiac/Pulmonary Rehab Coordinator. Others may be invited to attend when considered necessary or desirable.

12.10-2 DUTIES
1. This Committee shall be responsible for the following:
   a. Review and evaluate medical records to determine whether they:
   b. Properly describe the condition and progress of the patient, the therapy provided, and results thereof and provide adequate identification and records of individual responsibility for all actions taken
   c. Are sufficiently complete at all times to facilitate continuity of care and communications between all individuals providing patient care services in the hospital

12.10-3 MEETINGS
This Committee shall meet at least quarterly and provide reports to the Medical Staff regarding its activities. If such reports are oral, a written summary of the report shall be prepared.

12.11 CRITICAL ACCESS HOSPITAL ADVISORY COMMITTEE

12.11-1 COMPOSITION
Membership shall consist of at least one representative of the Medical Staff, one or more physician's assistants, nurse practitioners or clinical nurse specialists and at least one member not on staff at Jackson County Regional Health Center. Additional members may be appointed from management, clinical or ancillary areas as necessary.

12.11-2 DUTIES
This Committee shall be responsible to assist in the development and/or review of all patient care policies and procedures. The committee may also be used to address other issues related to the hospital's participation in the Critical Access Hospital program as deemed necessary by hospital management.

12.11-3 MEETINGS

This Committee shall meet a minimum of six times per year and reports to the Medical Executive Committee will be made as requested.

12.12 OTHER

All other Committee functions not specified above shall be the responsibility of the Medical Executive Committee. The Chief of Staff shall also be authorized to appoint such other committees as shall from time to time be deemed necessary or desirable. Such Committees shall confine their work to the purpose for which they were created and shall report to the full Medical Staff unless otherwise specified. Special Committees shall not have power to act unless such power is specifically granted by the motion which created the Committee.

ARTICLE XIII: MEETINGS

13.1 MEETINGS

13.1-1 ANNUAL MEETING

The annual meeting of the Medical Staff shall be in January of each year. At this meeting the retiring officers and committees shall make such reports as may be required, officers for the ensuing term shall be elected, and the Chief of Staff shall present a report on actions taken during the year and on other matters believed to be of interest to the membership. Notice of the annual meeting shall be given to the membership at least twenty (2) days prior to the meeting.

13.1-2 REGULAR MEETINGS

There shall be a regular meeting of the membership quarterly (every 3 months) in a calendar year. The annual meeting occurring in January of each Medical Staff year shall constitute the regular meeting.

The Medical Staff shall, by standing resolution, designate the date, time, and place for all regular Staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Staff in the same manner as provided in Section 13.1-4 of this Article XIII for notice of a special meeting.

13.1-3 AGENDA

The agenda at regular meetings shall be:

1. Administrative:
   a. Call to order
   b. Acceptance of the minutes of the last regular and of all special meetings.
2. Unfinished business.
3. Communications.
4. Report from the Chief Executive Officer of the Hospital
5. New business (including elections, where appropriate)
6. Reports of Medical Staff committees
7. Discussion and recommendations for improvement of professional work of the hospital
8. Adjournment

13.1 -4 SPECIAL MEETINGS

1. Special meetings of the Medical Staff may be called at any time by the Chief of Staff, and shall be called at the request of the Governing Board, or at least one-fourth of the members of the Active Medical Staff. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Written notice shall be distributed to each physician and posted on the bulletin board in the Medical Staff dictation room at least seventy-two (72) hours prior to the time of the meeting. The attendance of a member of the Medical Staff at a special meeting shall constitute waiver of notice of such meeting.
2. The agenda at special meetings shall be:
    a. Reading of the notice calling the meeting
    b. Transaction of business for which the meeting was called
    c. Adjournment.

13.1-5 Quorum

The presence of a minimum of 50% or 3 members of the total membership of the Active Medical Staff at any regular or special meeting shall constitute a quorum.

13.1-6 ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. The Chief of Staff or his designated presiding officer shall be permitted to vote. No proxy voting and no cumulative voting shall be permitted. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Action may be taken without a meeting by a Service, committee or the Medical Executive Committee by a written memo or letter_setting forth the action so taken signed by each member to vote.

13.1-7 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the Secretary and forwarded to the CEO. Each Committee shall maintain a permanent file of the minutes of each meeting.

13.1-8 ATTENNDANCE REQUIREMENTS

1. Each member of the Active Staff shall be required to attend the annual meeting of the Medical Staff, and members of the Active Staff shall be required to attend at least 75% of all other regular Medical Staff meetings in each year. A member who is

compelled to be absent from the annual or any regular Staff Meeting shall promptly provide to the Chief of Staff the reason for such absence. Unless excused for good cause, failure to meet the annual attendance requirements, or unexcused absence from three consecutive regular meetings, shall be grounds for any of the corrective actions specified in Section 8.1-4.

2. Reinstatement to the Active Staff or Associate Staff of members whose membership has been revoked because of absences from meetings may be made on application, the procedure being the same as in applications for original appointment.

13.2 COMMITTEE AND SERVICE MEETINGS

13.2-1 REGULAR MEETINGS

Committees and Services may, by resolution, provide the time for holding regular meetings, and no notice other than such resolution shall then be required.

13.2-2 SPECIAL MEETINGS

A special meeting of any Committee or Service may be called by or at the request of the Chairman or Chief thereof, by the Chief of Staff, the Medical Executive Committee, or by one-third of the group's then members, but not less than two members.

13.2-3 NOTICE OF MEETINGS

Written or oral notice of the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the Committee or Service not less than seventy-two (72) hours before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States Mail addressed to the member at his address as it appears on the records of the Hospital. The attendance of a member at a meeting shall constitute a waive of notice of such meeting.

13.2-6 ATTENDANCE

Each Committee or Service member shall be required to attend not less than fifty percent (50%) of all meeting of his Committees or Services in each year. The reason provided for any absences and the action of the Committee Chairman or Service Chief thereon shall be shown in the minutes. The failure to meet the foregoing annual attendance requirements, unless excused by the Committee Chairman for good cause shown, shall be grounds for any of the corrective actions specified in Section 8.1-4, including, in addition, removal from a Committee or Service. Committee Chairmen and Service Chiefs shall report such failures to the Medical Executive Committee for action. Attendance at Committee and Service meetings shall apply to all persons assigned to Committees and Services, whether members of Active or Associate Staff of AHP's.

ARTICLE XIV: CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

1. INFORMATION means all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures, whether in written, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.
2. HEALTH PRACTITIONER means a practitioner or an allied health professional.
3. REPRESENTATIVE means a board, any trustee, a committee, a chief executive officer or administrator of a hospital or other health care institution or their designee, a medical staff entity, an organization of health practitioners, a PRO, a state or local board of medical or professional quality assurance, and any members, officer, department, service of committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
4. THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising clinical or practice privileges within this Hospital, an applicant thereby:

1. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing, or reasonably believed to bear, on his professional ability and qualifications.
2. Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the Hospital and its Medical Staff.
3. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
4. Acknowledges that the provisions of this Article are express conditions to his application for any acceptance of Medical Staff membership and the continuation of such membership or to his exercise of clinical privileges at the Hospital, or to his application for or acceptance of approval and exercise of practice privileges at the Hospital.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any health practitioner submitted, collected or prepared by any representative for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall be confidential, to the fullest extent permitted by law, and shall not be disseminated to anyone other than a representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

This information shall become a part of the Medical Staff Committee files and shall not become part of a particular patient's record or of the general records of the Hospital.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

Each representative of the Hospital, including its Medical Staff members, shall be exempt, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief for any other taken or statement or recommendation made within the scope of his duties as a representative.

14.4-2 FOR PROVIDING INFORMATION

Each representative of the Hospital, including its Medical Staff members, and all third parties, shall be exempt to the fullest extent permitted by law from liability to a health practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative concerning a health practitioner.

14.5 ACTIVITIES AND INFOIRMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, proceedings, interviews, reports, records, minutes, memoranda, statements, forms, findings, recommendations, evaluations, opinions, conclusions or disclosures made or performed in connection with this or any other health care facility's or organization's activities, but not limited to:

1. Applications for appointment, reappointment, clinical privileges, practice privileges and prerogatives and periodic reappraisals of a health practitioner's membership, privileges, and/or prerogatives.
2. Corrective action.
3. Hearings and appellate reviews.
4. Hospital, service, committee, or other medical staff activities related to monitoring, maintaining and improving the quality of patient care, appropriate utilization and appropriate professional conduct.
5. Pro and like reports.

14.6 RELEASES

Each health practitioner, upon request of the Hospital, shall execute general and specific releases in accordance with the provisions, tenor and import of this Article. Execution of such releases shall not, however, be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XV: GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each practitioner and AHP in the Hospital. Such Rules and Regulations shall be a part or these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present, without previous notice or at any special meeting on proper notice, by a majority vote of the Active Medical Staff members present. Such changes shall become effective only after approval by the Governing Board, which approval shall not be unreasonably withheld.

15.1-2 SERVICES RULES AND REGULATIONS

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

15.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner and AHP shall be required, as a prior condition of initial appointment and reappointment and/or the granting or continued exercise of privileges, to present a current certificate of insurance, form an insurance company licensed or approved by the Commissioner of Insurance to do business in the State of Iowa, verifying professional liability insurance coverage of at least $500,000 per claim or medical incident. Each member shall report any reduction, restriction, cancellation or termination of the required professional liability insurance coverage or change in insurance carrier as soon as reasonably practical to do so to the CEO and the Medical Executive Committee.

15.3 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices or Chief of a Service shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities of responsibilities on behalf of the Medical Staff.

15.4 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

15.5 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Executive Committee or his or its designee, and they shall first confer with the CEO. Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee, the Medical Staff or Governing Board may deem necessary.

15.6 ACCEPTANCE

All members of whatever class or category, by application for membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws as they now exist and as they may be amended form time to time, a copy of which shall be delivered or made available to each member on his initial appointment and throughout the duration of his membership on the Staff. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or Governing Board shall direct.

15.7 DIVISION OF FEES

The practice of this division of professional fees, or "fee-splitting" under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff. It shall be understood, however, that a compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice does not constitute an unlawful decision of fees.

15.8 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to the Hospital, Governing Board, Medical Staff or officers of Committees thereof, the notice shall be addressed as follows:

Name and Title of Addressee
Jackson County Regional Health Center
700 West Grove Street
Maquoketa, Iowa 52060

In the case of a notice to a practitioner, AHP, or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery and if mailed as provided by above, such notice shall be effective two days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

15.9 CONFLICTS

In the event of conflicting or inconsistent provisions in the Medical Staff Bylaws and the Rules and Regulations, the Bylaws shall control. In the event of conflicting or inconsistent provisions in the Medical Staff Bylaws and the Hospital Bylaws, the Hospital Bylaws shall control.

ARTICLE XVI-CONFLICT MANAGEMENT PROCESS

The Hospital is committed to managing conflicts between the Medical Staff and the Medical Executive Committee while always protecting the quality and safety of patient care.

In the event that a majority of voting members of Medical Staff sign a petition or otherwise evidence disagreement with any action taken by the Medical Executive Committee, the provisions of this Article, the conflicts management process shall be deemed initiated. The petition must clearly state basis of disagreement and may include other factual information. Each petitioner who executes such petition must acknowledge he/she has read the petition and all attachments for it to be valid. Once the Conflict Management Process threshold is achieved the petition (and attachments) and list of all petitioners must be forwarded to the Medical Executive Committee. Within 30 days of Medical Executive Committee's receipt of the petition, there must be a meeting between representatives of the Medical Executive Committee and the petitioners or their designated representatives. All parties must act in good faith and take reasonable steps to resolve the dispute.

If the Medical Executive Committee and petitioners resolve the conflict, the resolution is submitted to the organized Medical Staff and upon approval, the proposals is forwarded to the Governing Board for review and consideration.

If the parties fail to achieve resolution or if voting members of the Medical Staff do not approve, the proposed resolution and all materials are sent to the Governing Board for review, consideration and action. The decision of the Governing Board shall be final.

For the avoidance of doubt, nothing in this Article precludes direct communication between an individual member and the Governing Board on any Rule & Regulation or policy adopted by the Medical Staff or the Medical Executive Committee. Such communication should be forwarded to the Governing Board through the Hospital CEO and to the Medical Executive Committee through the Medical Staff Chief of Staff (President). Any such communication should be in written form and will be referred to the Governing Board.

ARTICLE XVII: ADOPTION AND AMENDMENT OF BYLAWS

17.1 PROCEDURE

17.1-1 INITIATED BY MEDICAL STAFF

On the request of the Chief of Staff, the Medical Executive Committee, or on timely written petition signed by at least twenty (20) percent or three (3) members of the Medical Staff in good standing who are entitled to vote or follow the interim approval of a Bylaw change enacted by the Medical Executive Committee in accordance with Section 12.2 of these Bylaws, consideration shall be given to the adoption, amendment or repeal of these Bylaws. This action shall be taken at a regular or special meeting, provided (1) written notice of the proposed change was sent to all members entitled to regular or special meeting of the Medical Staff; and (2) notice was given of the next regular or special meeting at which action is to be taken including notice that a Bylaws change would be considered. Both notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change (s).

17.1-2 INITIATED BY GOVERNING BOARD

If theses Bylaws are not in compliance with the requirements imposed by law regulation, court order for accreditation, for tax purposes, or are otherwise necessary to avoid adverse action or sanction against the Hospital, the Governing Board may request appropriate amendment. The Medical Staff shall take action on that amendment at its next regular meeting, following requisite notice, unless sanctions will be imposed upon the Hospital in the absence of amendment prior to the next regular meeting, in which case a special meeting of the Medical Staff or Medical Executive Committee shall be called within a reasonable time to act thereon. Such amendment as is proposed by the Governing Board that is necessary to comply with law, regulation, court order or accreditation requirements or tax purpose, or to avoid adverse action or sanction against the Hospital, shall be deemed adopted by the Medical Staff unless the Medical Staff takes action that amends these Bylaws to conform to such requirements.

17.2 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a Bylaws change, the change shall require an affirmative vote of two-thirds of the members voting in person or by written ballot.

7.3 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Governing Board, which approval shall not be withheld unreasonably, or automatically written 90 days if no action is taken by the Governing Board.

17.4 EXCLUSIVITY

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

ADOPTED by the Medical Staff on 07/15/14

Chief of Staff

Secretary/Treasurer

Approved by the Governing Board on 07/22/14

Chair

Secretary