MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS MEMORIAL HEALTH

JACKSONVILLE MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions will apply to terms used in these Bylaws:

(1) "ADMINISTRATIVE LEADERSHIP" means the CEO, Chief Medical Officer, Chief Nursing Officer, or any Administrator on call.

(2) "ADMITTING PRACTITIONER" means a Practitioner who, within the scope of his or her clinical privileges (e.g., a physician, podiatrist, or dentist, but generally not an APP), orders the admission of a given patient to the Hospital and who has the responsibilities outlined in the Medical Staff Rules and Regulations.

(3) "ADVANCED PRACTICE PROFESSIONAL" ("APP") is a type of Practitioner who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who may be required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising/Collaborating Physician pursuant to a written supervision/collaborative agreement. See **Appendix B**.

(4) "ALLIED HEALTH PROFESSIONAL" means an individual who is permitted by law or the Hospital to function only under the direction of a Supervising/Collaborating Physician, pursuant to a written supervision/collaboration agreement and consistent with a defined Scope of Practice. Except as noted in these Bylaws, all aspects of the clinical practice of Allied Health Professionals at the Hospital shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures and the provisions of these Bylaws shall specifically not apply. Hereafter, the Medical Staff Bylaws and associated policies shall not apply to Allied Health Professionals (except for Article 13 of these Bylaws). See **Appendix C**.

(5) "AMBULATORY CARE LOCATION" means any department in the Hospital or provider-based site or facility where ambulatory care is provided (i.e., non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy).

(6) "APPOINTMENT" means the granting of membership to the Medical Staff by the Board to one of the defined categories outlined in Article 2 of the Medical Staff Bylaws or the granting of Permission to Practice to an Advanced Practice Professional or Licensed Independent Practitioner.

(7) "ASSIGNED REVIEWER" means a Practitioner, or an individual who has been granted clinical privileges at another entity affiliated with Memorial Health System, who is appointed by a CSR or the Leadership Council to either: (i) serve as a consultant to the individual or committee performing the review; or (ii) conduct a review, document his/her clinical findings on the AR Case Review Form (see PPE-5 in the PPE Manual), submit the form to the individual or committee that assigned the review, and be available to discuss his/her findings and answer questions. The functions of an Assigned Reviewer may also be performed by a standing or ad hoc committee as requested by the CSR or the Leadership Council.

(8) "ATTENDING PHYSICIAN" means the Physician who shall be responsible for directing and supervising a patient's overall medical care and who has the responsibilities outlined in the Medical Staff Rules and Regulations.

(9) "BOARD" means the Board of Directors of the Hospital or its designated committee.

(10) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(11) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Board to act as the chief medical officer of the Hospital, in cooperation with the Medical Staff President.

(12) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and FPPE and OPPE standards. There are several types of clinical privileges, including, but not limited to, Telemedicine Privileges, Temporary Privileges, and Disaster Privileges.

(13) "COLLEGIAL COUNSELING" means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial counseling only occurs after a Practitioner has had an opportunity to provide input regarding a concern.

(14) "CONFIDENTIAL FILE" means any file, paper or electronic, containing credentialing, privileging, PPE/Peer Review, or quality information related to a Practitioner.

(15) "CONSULTING PRACTITIONER" means a Practitioner who examines a patient to render an opinion and/or advice to a requesting Physician (or his or her designee) and who has the responsibilities outlined in the Medical Staff Rules and Regulations.

(16) "CORE PRIVILEGES" means a defined grouping of Privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(17) "DAYS" means calendar days.

(18) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(19) "DEPARTMENT CHAIR" means the applicable head of a Medical Staff department at the Hospital (e.g., Chair of Medicine).

(20) "EDUCATIONAL LETTER" is a letter that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice.

(21) "EMPLOYED PRACTITIONER" means a Practitioner who is employed by an Employer.

(22) "EMPLOYER" means:

(a) the Hospital; or

(b) a Hospital-related entity or a private entity that:

(i) has a formal peer review process and an established peer review committee; and

(ii) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

(23) "FOCUSED PROFESSIONAL PRACTICE EVALUATION" or "FPPE" means a time-limited period during which a Practitioner's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial Appointment, Reappointment, or during the term of Appointment, shall be subject to FPPE.

(24) "HOSPITAL" means Jacksonville Memorial Hospital and any outpatient facilities that bill under the Hospital's Medicare certification number.

(25) "INFORMATIONAL LETTER" is a letter that is intended to help Practitioners self-correct and improve their performance through timely feedback. The

Leadership Council will prepare a list of objective occurrences (i.e., not subject to interpretation) for which an Informational Letter is appropriate.

(26) "INITIAL MENTORING EFFORTS" means informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Counseling. The Medical Staff policies encourage the use of Initial Mentoring Efforts to assist Practitioners in continually improving their practices. There is no expectation that input be obtained prior to Initial Mentoring Efforts or that they be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the Practitioner's Confidential File.

(27) "INVESTIGATION" means a non-routine, formal process to review questions or concerns pertaining to a Practitioner. Only the Medical Executive Committee has the authority to initiate and conduct an Investigation. By contrast, the processes that address issues of clinical performance, professional conduct, and health involving Practitioners that utilize Initial Mentoring Efforts or Progressive Steps do not constitute Investigations.

(28) "LEADERSHIP COUNCIL" is a peer review committee under Illinois law that:

(a) reviews, or determines the appropriate review process for, certain clinical issues as described in the Professional Practice Evaluation Policy (Peer Review);

(b) handles issues of professional conduct pursuant to the Medical Staff Professionalism Policy; and

(c) handles issues of Practitioner health pursuant to the Practitioner Health Policy.

The Leadership Council has no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the Leadership Council are described in Article 5 of these Bylaws.

(29) "LICENSED INDEPENDENT PRACTITIONERS" ("LIPs") means a type of Practitioner other than a Medical Staff member who is permitted by law and by the Hospital to provide patient care services without direction or collaboration/ supervision, within the scope of his or her license and consistent with the clinical privileges granted. Licensed Independent Practitioners also include those Physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in these Bylaws (i.e., moonlighting residents). See **Appendix D**.

(30) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee.

(31) "MEDICAL STAFF" means all Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, and Psychologists who have been appointed to the Medical Staff by the Board.

(32) "MEDICAL STAFF LEADER" means any Medical Staff Officer, Department Chair, and committee chair.

(33) "MEDICAL STAFF MEMBER" means any Physician, Dentist, Oral and Maxillofacial Surgeon, Podiatrist, or Psychologist who has been granted Appointment by the Board.

(34) "MEDICAL STAFF SERVICES" means the Medical Staff Office at the Hospital or any delegated Credentials Verification Office ("CVO").

(35) "MEMORIAL HEALTH" means the hospitals and related facilities that are governed by Memorial Health.

(36) "NOTICE" means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.

(37) "ONGOING PROFESSIONAL PRACTICE EVALUATION" or "OPPE" means the ongoing review and analysis of data that helps to identify any issues or trends in Practitioners' performance that may impact quality of care and patient safety. OPPE promotes an efficient and effective evidence-based Reappointment process. It is also part of the effort to provide educational opportunities that help all Practitioners consistently provide quality, safe, and effective patient care.

(38) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(39) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Hospital or its hospital-based clinics. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.

(40) "PERMISSION TO PRACTICE" means the authorization granted to Advanced Practice Professionals and Licensed Independent Practitioners to exercise clinical privileges at the Hospital.

(41) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(42) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(43) "PRACTITIONER" means any individual who has been granted clinical privileges and/or Appointment by the Board, including, but not limited to, Medical Staff Members, Advanced Practice Professionals, and Licensed Independent Practitioners.

(44) "PROCEDURALIST" means a Practitioner (e.g., surgeon) who performs an operative procedure with the scope of his or her clinical privileges in the Hospital and who has the responsibilities outlined in the Medical Staff Rules and Regulations.

(45) "PROFESSIONAL PRACTICE EVALUATION" or "PPE" refers to the Hospital's routine peer review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise. The PPE process outlined in the Professional Practice Evaluation Policy (Peer Review) is applicable to all Practitioners and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

(46) "PROFESSIONAL PRACTICE EVALUATION SPECIALISTS" or "PPE SPECIALISTS" means the clinical and non-clinical staff who support the professional practice evaluation process described in the Professional Practice Evaluation Policy (Peer Review) and who act at the direction of the Leadership Council. Such individuals may include, but are not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department. PPE Specialists act on behalf of the Leadership Council and documentation they create are records of the Leadership Council. The Leadership Council Chair or CMO may direct PPE Specialists to perform functions under the Professional Practice Evaluation Policy (Peer Review) on behalf of the Leadership Council.

(47) "PROGRESSIVE STEPS" means Informational Letters, Educational Letters, Collegial Counseling, and Voluntary Enhancement Plans.

(48) "PSYCHOLOGIST" means an individual with a Ph.D. or a Psy.D. in clinical psychology.

(49) "REAPPOINTMENT" means the granting of continued Appointment to the Medical Staff by the Board or the granting of continued Permission to Practice to an Advanced Practice Professional or Licensed Independent Practitioner.

(50) "REQUESTING PRACTITIONER" means a Practitioner who makes a request for a consultation in accordance with the Medical Staff Rules and Regulations.

(51) "RESPONSIBLE PRACTITIONER" means any Practitioner, including a Consulting Practitioner, who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in the Medical Staff Rules and Regulations. These responsibilities include the completion of medical record entries related to the specific care/services he or she provides.

(52) "RESTRICTION" means a professional review action that:

(a) is recommended by the Medical Executive Committee as part of an Investigation or agreed to by the Practitioner while he or she is under Investigation or in exchange for the Medical Executive Committee not conducting an Investigation or taking an adverse professional review action; and

(b) limits the individual's ability to independently exercise his or her clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring requirement in which the proctor must be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the Medical Executive Committee or by any other Medical Staff committee:

(a) general consultation requirements, in which the Practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the Practitioner agrees to have a proctor present to observe his or her provision of care; and

(c) other collegial performance improvement efforts, including Informational Letters, Educational Letters, or Voluntary Enhancement Plans that are suggested by the Medical Staff leadership and voluntarily agreed to by the Practitioner as a part of the routine PPE process.

(53) "SCOPE OF PRACTICE" means the authorization granted to an Allied Health Professional by the Board to perform certain clinical activities and functions under the Supervision of, or in collaboration with, a Supervising/Collaborating Physician.

(54) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(55) "SPECIAL PRIVILEGES" means clinical privileges that fall outside of the Core Privileges for a given specialty, which require additional education, training, and/or experience beyond that required for Core Privileges in order to demonstrate competence.

(56) "SUPERVISING/COLLABORATING PHYSICIAN" means a Medical Staff Member with clinical privileges who has agreed in writing to supervise/collaborate with an Advanced Practice Professional or an Allied Health Professional and to accept full responsibility for the actions of the Advanced Practice Professional or Allied Health Professional while he or she is practicing in the Hospital.

(57) "SUPERVISION/COLLABORATING" means the supervision of, or collaboration with, an Advanced Practice Professional or an Allied Health Professional by a Supervising/Collaborating Physician, that may or may not require the actual presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the Supervising/Collaborating Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Advanced Practice Professional or Allied Health Professional is credentialed and shall be consistent with any applicable written Supervision/Collaboration agreement that may exist.

(58) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(59) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an Attending Physician, or whose Attending Physician or designated alternate is unavailable to attend the patient. If a patient does not want the prior Attending Physician to provide him or her care while a patient at the Hospital, the matter will be managed in accordance with the Medical Staff Rules and Regulations.

(60) "VOLUNTARY ENHANCEMENT PLAN" or "VEP" is a voluntary agreement between a Practitioner and the Leadership Council by which the Practitioner takes certain steps to improve his or her clinical practice or conduct. A Practitioner cannot be compelled to participate in a VEP. If a Practitioner disagrees with the need for a VEP developed by the Leadership Council, the matter is referred to the Medical Executive Committee for its independent review and action pursuant to these Bylaws. Additional guidance on VEPs is found in the Professional Practice Evaluation Policy (Peer Review) and the Medical Staff Professionalism Policy.

(61) "VOTING STAFF" means those Practitioners who have been given the right to vote in all general and special meetings of the Medical Staff. Voting rights are defined in the prerogatives of each Medical Staff category in Article 2 of the Medical Staff Bylaws.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Administrative Leadership, by a Medical Staff member, or by a Medical Staff

committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under these Bylaws is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of these Bylaws, substantial compliance is required. Technical or minor deviations from the procedures set forth within these Bylaws do not invalidate any review or action taken.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary depending upon staff category and/or clinical privilege status.

(2) Dues shall be payable upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the Medical Staff President and Secretary.

ARTICLE 2

MEDICAL STAFF CATEGORIES

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in these Bylaws are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix E** to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

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

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his or her two-year appointment term shall not be eligible to request Active Staff status at the time of his or her reappointment.

** The member will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Ambulatory Care, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in their specific delineation of clinical privileges, the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(c) hold office, serve as Department Chairs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting inpatient consultations, when requested;

(g) paying any applicable dues and assessments; and

(h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least six, but fewer than 24, patient contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the MEC at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than six patient contacts during his or her two-year appointment term will be transferred to another staff category that accurately reflects his or her relationship to the Medical Staff and the Hospital (options – Consulting, Ambulatory Care, or Coverage).

** Any member who has 24 or more patient contacts during his or her two-year appointment term shall be automatically transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and department meetings (without vote);

(b) may not hold office or serve as Department Chairs or committee chairs;

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician,

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall exercise such clinical privileges as are granted to them; and

(g) shall pay any applicable dues and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as Department Chairs or committee chairs;

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

(d) may be invited to serve on committees (with vote);

(e) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients;

(f) shall cooperate in the professional practice evaluation and performance improvement processes; and

(g) shall pay any applicable dues and assessments.

2.D. AMBULATORY CARE STAFF (WITH OR WITHOUT OUTPATIENT PRIVILEGES)

2.D.1. Qualifications:

(a) The Ambulatory Care Staff (with Outpatient Privileges) consists of those physicians, dentists, oral surgeons, and podiatrists who:

(1) meet the eligibility criteria set forth in Section 7.A.1 of these Bylaws;

(2) wish to request only limited outpatient privileges for the care and treatment of their patients; and

(3) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

(b) The Ambulatory Care Staff (without Outpatient Privileges) consists of those physicians, dentists, oral surgeons, and podiatrists who:

(1) meet the eligibility criteria set forth in Section 7.A.1 of these Bylaws, with the exception of those related to board certification, response times, emergency call coverage, coverage arrangements, and eligibility criteria for clinical privileges; and

(2) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

The primary purpose of the Ambulatory Care Staff (without Privileges) is to permit these individuals to access Medical Center services for their patients by referral of patients to Active Staff members for admission and care and to promote professional and educational opportunities, including continuing medical education.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

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

(b) may not hold office or serve as Department Chairs or committee chairs;

(c) may be invited to serve on committees (with vote);

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

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

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

(i) may perform history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may not: admit patients, attend patients, exercise clinical privileges (unless outpatient privileges are requested and granted), write inpatient orders or progress notes, make entries in the medical record, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) must accept referrals from the Emergency Department for follow-up care of patients treated and released from the Emergency Department;

(l) may refer patients to the Hospital's diagnostic facilities and order such tests;

(m) may actively participate in the professional practice evaluation and performance improvement processes; and

(n) shall pay any applicable dues and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy any defined response time requirements in place at the Hospital, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member who is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as Department Chairs or committee chairs;

(e) may be invited to serve on committees (with vote); and

(f) shall pay any applicable dues and assessments.

2.F. LOCUM TENENS STAFF

2.F.1. Qualifications:

The Locum Tenens Staff will consist of Practitioners who desire to provide services at the Hospital in accordance with the locums tenens privileges granted through these Bylaws.

2.F.2. Prerogatives and Responsibilities:

Locum Tenens Staff members:

(a) may admit patients and exercise such clinical privileges as are granted;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be invited to serve on committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Department Chairs or committee chairs; and

(f) shall pay any applicable dues and assessments.

2.G. HONORARY STAFF

2.G.1. Qualifications:

(a) The Honorary Staff shall consist of Practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years, who are in good standing, and who have been recommended for Honorary Staff appointment by the MEC.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.G.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be invited to serve on committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Department Chairs or committee chairs; and

(f) are not required to pay dues or assessments.

2.H. CLINICAL PRIVILEGES WITHOUT APPOINTMENT

The following types of affiliations with the Hospital include a grant of clinical privileges only. Practitioners with the below types of relationships with the Hospital are not considered to be members of the Medical Staff and shall not be granted Medical Staff appointment:

(1) moonlighting physicians in training;

(2) non-ACGME fellowship applicants;

(3) temporary privileges (important patient care need); and

(4) telemedicine providers.

ARTICLE 3

MEDICAL STAFF OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Medical Staff President, Medical Staff President-Elect, Immediate Past Medical Staff President, and Secretary.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff, who satisfy the following criteria initially and continuously, as determined by the MEC, shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Board. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years;

(2) have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) not presently be serving as a Medical Staff officer, Board member or department chief at any other hospital outside of Memorial Health and shall not so serve during their term of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position or other involvement in performance improvement functions in a hospital setting;

(6) attend continuing education relating to Medical Staff leadership, credentialing, and/or peer review functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a Practitioner's office and billed under the same provider number used by the Practitioner. The MEC shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

3.C. DUTIES

3.C.1. Medical Staff President:

The Medical Staff President shall:

(a) act in coordination and cooperation with Administrative Leadership in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the CEO and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(d) chair the MEC and Leadership Council (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;

(e) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(f) serve as an advisory member of the Medical Executive Committee of the Board; and

(g) perform all functions authorized in all applicable policies, including collegial intervention in these Bylaws.

3.C.2. Medical Staff President-Elect:

The Medical Staff President-Elect shall:

(a) assume all duties of the Medical Staff President and act with full authority as Medical Staff President when the Medical Staff President is unavailable within a reasonable period of time;

(b) serve on the MEC and the Leadership Council, with vote;

(c) serve as a member of the Joint Conference Committee; and

(d) assume all such additional duties as are assigned to him or her by the Medical Staff President or the MEC.

3.C.3. Immediate Past Medical Staff President:

The Immediate Past Medical Staff President shall:

(a) serve on the MEC and Leadership Council, with vote;

(b) serve as an advisor to other Medical Staff leaders; and

(c) assume all duties assigned by the Medical Staff President or the MEC.

3.C.4. Secretary:

The Secretary shall:

(a) serve as a member of the MEC;

(b) attend to all appropriate correspondence and notices on behalf of the Medical Staff, as may be requested;

(c) be a signatory on the Hospital's Medical Staff account; and

(d) perform such additional duties as are assigned by the President of the Medical Staff, the MEC, or the Board.

3.D. NOMINATIONS

(1) The Leadership Council shall convene at least 45 days prior to the election and shall submit the names of at least one qualified nominee for any vacant Medical Staff officer position. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 21 days prior to the election.

(2) Additional nominations may also be submitted in writing by petition signed by at least five members of the Voting Staff at least 14 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Council, and be willing to serve.

(3) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Elections shall be held solely by written or electronic ballot returned to Medical Staff Services in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Voting Staff and completed ballots must be received in Medical Staff Services by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Voting Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected or appointed.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC or the Active Staff, or by the Board for:

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

(b) failure to perform the duties of the position held;

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

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

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Board, as applicable, prior to a vote on removal.

3.H. VACANCIES

A vacancy in the office of Medical Staff President shall be filled by the Medical Staff President-Elect, who shall serve until the end of the Medical Staff President's unexpired term. In the event there is a vacancy in the Medical Staff President-Elect or Secretary position, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into departments as determined by the MEC and listed in these Bylaws. The MEC may create new departments, eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure, in accordance with the amendment provisions contained in these Bylaws.

(2) Clinical departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(a) The following factors shall be considered in determining whether a clinical department should be created:

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

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

(iii) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(iv) it has been determined by the Medical Staff leadership and the CEO that there is a clinical and administrative need for a new department; and

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

(b) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:

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

(ii) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

(iii) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(iv) no qualified individual is willing to serve as a Department Chair; or

(v) a majority of the voting members of the department vote for its dissolution.

(3) The following clinical departments are established:

- Medicine; and
- Surgery.

4.B. ASSIGNMENT TO DEPARTMENTS

(1) Upon initial appointment to the Medical Staff, each Medical Staff member shall be assigned to a clinical department. Assignment to a particular department does not preclude a Medical Staff member from seeking and being granted clinical privileges typically associated with another department.

(2) A Medical Staff member may request a change in department assignment to reflect a change in his or her clinical practice.

(3) Department assignment may be transferred at the discretion of the MEC.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges in a given department, and (iii) to assure emergency call coverage for each specialty within the department for all patients.

4.D. QUALIFICATIONS OF ELECTED DEPARTMENT CHAIRS

Each clinical Department Chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Board after considering the recommendation of the President of the Medical Staff.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS

(1) Except as otherwise provided by contract, Department Chairs shall be elected by the department, subject to MEC approval and confirmation by the Board. Candidates will be identified by the Leadership Council and must meet the qualifications in Section 3.B, unless waived by the MEC. The election shall be by written or electronic ballot. Ballots may be returned in person, by mail, or by facsimile by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no one is willing to serve as a Department Chair, the Medical Staff President shall appoint an individual, in consultation with the MEC.

(2) Any Department Chair may be removed by a two-thirds vote of the department or by a two-thirds vote of the MEC after reasonable notice and opportunity to be heard. Grounds for removal shall be:

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

(b) failure to perform the duties of the position held;

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

(d) an infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the Medical Staff member shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The Medical Staff member shall be afforded an opportunity to speak to the department or MEC, as applicable, prior to a vote on such removal being taken.

(4) Each Department Chair shall serve a term of two years and may be reelected for additional terms if nominated by the Leadership Council.

4.F. DUTIES OF DEPARTMENT CHAIRS

Department Chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) all clinically-related activities of the department;

(2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) the integration of the department into the primary functions of the Hospital;

(7) the coordination and integration of interdepartmental and intradepartmental services;

(8) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(9) determination of the qualifications and competence of department personnel who are not licensed independent Practitioners and who provide patient care, treatment and services;

(10) recommendations for a sufficient number of qualified and competent persons to provide care or services;

(11) continuous assessment and improvement of the quality of care and services provided;

(12) maintenance of quality monitoring programs, as appropriate;

(13) recommendations for space and other resources needed by the department;

(14) assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

(15) the orientation and continuing education of all persons in the department;

(16) assure emergency call coverage for each specialty within the department; and

(17) performing all functions authorized in these Bylaws, including collegial intervention.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the Leadership Council. Advanced Practice Professionals and Licensed Independent Practitioners may be appointed to serve as voting members of Medical Staff committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, and all committee members must signify their willingness to meet basic expectations of committee membership as set forth in Section 5.C of these Bylaws.

(2) Committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Leadership Council.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO, in consultation with the CMO and the Medical Staff President. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Medical Staff President, CMO, and the CEO shall be members, *ex officio*, without vote, on all committees.

5.C. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

5.D. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated in these Bylaws.

5.E. ICCU COMMITTEE

5.E.1. Composition:

The ICCU Committee shall be comprised of at least five Active Staff members (one of whom shall be the Medical Director of the ICCU), including three internal medicine physicians, a hospitalist, an Emergency Department physician, an anesthesiologist, and a surgeon. Administrative representatives shall include the ICCU nurse manager, the Telemetry unit nurse manager, the Emergency Department manager, the Clinical Director for those areas, and a member of Administration, all of whom shall be *ex officio* members.

5.E.2. Duties:

The ICCU Committee shall:

(a) be responsible for ongoing review of protocols for the ICCU;

(b) be responsible for ongoing review of the Quality Improvement Reports for the ICCU;

(c) conduct periodic evaluation of critical care policies and procedures as requested by Hospital Administration; and

(d) act as a critical care advisory committee to the Medical Staff Performance Improvement Committee or the MEC, when requested.

5.F. LEADERSHIP COUNCIL

5.F.1. Composition:

(a) The Leadership Council shall be comprised of the following members:

(1) Medical Staff President, who shall serve as Chair;

(2) Medical Staff President-Elect;

(3) Immediate Past Medical Staff President; and

(4) CMO.

(b) One or more PPE Specialists designated by the Leadership Council shall attend Leadership Council meetings to support the activities of the committee.

(c) Other appropriate individuals (e.g., Medical Staff members, Advanced Practice Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, etc.) may be invited to attend a particular Leadership Council

meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

(d) Between meetings of the Leadership Council, the Medical Staff President as Chair, in conjunction with another Leadership Council member, may take steps as necessary to implement and operationalize the decisions of the Leadership Council. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the Leadership Council's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

5.F.2. Duties:

The Leadership Council is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The Leadership Council makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The Leadership Council shall perform the following specific functions:

(a) Clinical PPE/Peer Review Functions

(1) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(2) review reports showing the number of cases being reviewed through the PPE Policy to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(3) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements;

(4) review, approve, and periodically update the quality indicators that will trigger the professional practice evaluation/peer review process;

(5) identify variances from rules, regulations, policies, or protocols which do not require Practitioner review, but for which an Informational Letter may be sent to the Practitioner involved in the case;

(6) review cases referred to it as outlined in the PPE Policy;

(7) develop, when appropriate, Voluntary Enhancement Plans for Practitioners, as described in the PPE Policy;

(8) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved; and

(9) work with Medical Staff Leaders to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through peer learning sessions or through some other mechanism.

(b) Review of Conduct and Health Issues and Other Functions

(1) review and address concerns about Practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;

(2) review and address possible health issues that may affect a Practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(3) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action;

(4) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(5) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers, to be presented to and elected by the Medical Staff;

(6) identify and nominate qualified individuals to serve as Department Chairs, to be presented to and elected by the relevant departments;

(7) appoint the chairs and members of all Medical Staff committees, except for the MEC;

(8) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(9) perform any additional functions as may be requested by the MEC or Board.

5.F.3. Meetings, Reports, and Recommendations:

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the MEC and others as described in the Policies noted above. The Leadership Council's reports to the MEC will provide summary and aggregate information

regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

5.G. MEDICAL EXECUTIVE COMMITTEE ("MEC")

5.G.1. Composition:

(a) The MEC shall consist of the following voting members:

- the President of the Medical Staff;
- the President-Elect of the Medical Staff;
- the Secretary of the Medical Staff;
- the Immediate Past President of the Medical Staff;
- the Department Chairs; and
- two at-large members selected by the MEC.

(b) The Leadership Council shall also appoint one Advanced Practice Professional to the MEC, with vote.

(c) The CEO, CMO, and President of the Board shall be *ex officio* members of the MEC, without vote.

(d) The Medical Staff President will chair the MEC.

(e) Other Medical Staff members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

5.G.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated; and

(7) hearing procedures;

(c) consulting with the CEO on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) reviewing, or delegating to the Bylaws Committee the responsibility to review, at least once every five years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) performing such other functions as are assigned to it by these Bylaws, the Board or other applicable policies.

5.G.3. Meetings:

The MEC shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

5.H. MEDICAL STAFF PERFORMANCE IMPROVEMENT COMMITTEE

5.H.1. Composition:

(a) The Medical Staff Performance Improvement Committee shall be comprised of at least five members of the Active Staff, not including the Chair, with at least one representative from each clinical department (Medicine and Surgery) and one member who is appointed to the Ambulatory Care Staff. *Ex officio* administrative members shall include the Quality Executive, the Chief Nursing Officer, the Director of Health Information Services, a Pharmacy representative, a Utilization Review representative, and other Hospital representatives as needed to address specific functions overseen by the Committee.

(b) To the fullest extent possible, Medical Staff Performance Improvement Committee members shall serve staggered, multiple-year terms, so that the Committee always includes experienced members. Appointed members may be reappointed for additional terms.

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff Performance Improvement Committee meeting (as guests, without vote) in order to assist the Medical Staff Performance Improvement Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and shall be bound by the same confidentiality requirements as the standing members of the Committee.

5.H.2. Duties:

The Medical Staff Performance Improvement Committee shall:

(a) maintain responsibility for making recommendations for improvement and taking action as appropriate concerning: medical studies, quality improvement activities, including, but not limited to, the specific functions of pharmacy and therapeutics, blood utilization review, infection control surveillance, utilization review, medical records, and the review of patient care activities throughout the Hospital, both inpatient and outpatient; and

(b) maintain oversight of the following specific functions:

(1) Pharmacy and Therapeutics: At least quarterly, with Hospital management, Nursing Service and Pharmacy represented, all matters relating to drug usage in the Hospital will be reviewed. Recommendations shall be made regarding evaluation, selection, availability, procurement, storage, distribution, control, safety, utilization and administration of drugs and intravenous additives by non-physician personnel. The complete Hospital formulary shall be reviewed at least annually;

(2) Blood Products: At least quarterly, the acquisition, storage and utilization of all blood products will be reviewed;

(3) Infection Control Surveillance: At least quarterly, infection control activities, nosocomial infection rate, and the recommendations of the Infection Control Committee will be reviewed with recommendations made to minimize infection hazards;

(4) Utilization Review: At least quarterly, the Committee will be provided with an overall review of utilization review activities in accordance with federal and state laws and as found in the Hospital's Utilization Review Plan. Concurrent referrals for physician review will be made as set forth in the Utilization Review Plan; and

(5) Patient Safety: At least quarterly, the Committee will be provided with an overall review of patient safety issues as identified by Quality Management and reported through the Patient Safety Committee of the Hospital.

5.H.3. Voting:

A simple majority vote is sufficient for all activities undertaken by the Medical Staff Performance Improvement Committee.

5.I. PERFORMANCE IMPROVEMENT FUNCTIONS

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

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

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

(3) medical assessment and treatment of patients;

(4) use of information about adverse privileging determinations regarding any Practitioner;

(5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(6) the utilization of blood and blood components, including review of significant transfusion reactions;

(7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

(11) coordination of care, treatment and services with other Practitioners and Hospital personnel;

(12) accurate, timely and legible completion of medical records;

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix F** of these Bylaws;

(14) the use of developed criteria for autopsies;

(15) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.J. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in these Bylaws, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual Medical Staff member, a standing committee, or a special task force shall be performed by the MEC.

5.K. SPECIAL COMMITTEES

Special committees shall be created and their Medical Staff members and chairs shall be appointed by the Medical Staff President. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

5.L. MEMORIAL HEALTH COMMITTEES

(1) The committees outlined in this Article are integrated committees of each individual Memorial Health Hospital Medical Staff.

(2) Each Memorial Health Hospital Medical Staff, through its Medical Staff President, shall designate one or more Medical Staff representatives as members of the committees. The Memorial Health President and Chief Executive Officer (or designee) will appoint all Memorial Health administrative representatives and shall designate a chair or chairs for each committee.

(3) All Memorial Health Committees shall meet as often as necessary to perform their duties. The committees shall report to each Memorial Health Hospital MEC at least annually.

(4) Minutes of all meetings of an Memorial Health Committee shall be maintained and shall contain information that is specific to each Memorial Health Hospital. Such minutes shall be made available so that they are accessible on site at each hospital.

(5) Because of the system-wide nature of these committees, each committee may establish additional rules concerning the conduct of meetings and their activities that may supplement or vary from other rules contained herein that are applicable to Medical Staff committees generally.

5.M. ADVANCED PRACTICE PROFESSIONALS COMMITTEE ("APPC")

5.M.1. Composition:

(a) The Advanced Practice Professionals Committee ("APPC") shall consist of Advanced Practice Professionals representing the range of areas in which APPs function within Memorial Health. The APPC may also obtain assistance, on an ad hoc basis, from the other representatives from the Medical Staffs, Nursing Staffs, and administration within Memorial Health.

(b) The System CMO and System CNO will serve as *ex officio* members of the committee, without vote.

5.M.2. Duties:

The APPC shall serve as an advisory/policy body to the Medical Staffs within Memorial Health. Its duties include, but are not limited to, the following:

(a) recommend standard policies, procedures, and guidelines pertaining to the practice of Advanced Practice Professionals within Memorial Health, including OPPE and FPPE measures/processes;

(b) develop recommendations for each type of Advanced Practice Professionals permitted to practice within Memorial Health, including, as appropriate:

(1) any specific education, experience and/or training qualifications that they must possess beyond those set forth in these Bylaws;

(2) detailed delineation of privileges forms, including eligibility criteria;

(3) any specific conditions that apply to their functioning within a hospital setting; and

(4) any supervision/collaboration requirements, if applicable;

(c) as may be requested, provide the Credentials Committee (or MEC if there is no Credentials Committee) with recommendations concerning an individual Advanced Practice Professional's application for clinical privileges;`

(d) in accordance with relevant policies, provide education and improvement assistance to individual Advanced Practice Professionals who have been granted clinical privileges within Memorial Health;

(e) evaluate and make recommendations regarding the need for the services that could be provided by types of Advanced Practice Professionals that are not currently permitted to practice within Memorial Health; and

(f) perform any additional functions as may be set forth in applicable policy or as requested by a Credentials Committee, MEC, or Board within Memorial Health.

5.M.3. Meetings, Reports, and Recommendations:

The APPC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions.

5.N. HEALTH INFORMATION MANAGEMENT COMMITTEE

5.N.1. Composition:

The Health Information Management Committee shall consist of at least one member from each Memorial Health Medical Staff, along with representatives from Memorial Health administration.

5.N.2. Duties:

The Health Information Management Committee shall perform the following functions:

(a) help assure that medical records are maintained in compliance with all applicable regulations, accreditation standards, and professional practice standards;

(b) monitor the conduct of audits regarding timeliness, completeness, and appropriateness of medical record documentation, and help assure that audit findings are reviewed and that follow-up recommendations are made as needed;

(c) track safety and quality data separately for each facility and assure that records are maintained on site at each hospital;

(d) make recommendations to the appropriate hospital Medical Staffs for action with respect to Medical Staff members who fail to conform to policies, including policies pertaining to timeliness and completeness of medical records;

(e) evaluate and make recommendations as appropriate regarding policies, rules and regulations relating to medical records; and

(f) engage in strategic planning for management of health information, including electronic medical record systems.

5.N.3. Meetings, Reports, and Recommendations:

The Health Information Management Committee shall meet as necessary to accomplish its functions, but at least four times per year.

5.O. PHARMACY AND THERAPEUTICS COMMITTEE

5.O.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least one member from each Memorial Health Medical Staff, the Director of Pharmacy at each Memorial Health Hospital, at least one representative from the nursing staff at each Memorial Health Hospital, and representatives from Memorial Health administration.

5.O.2. Duties:

The Pharmacy and Therapeutics Committee shall perform the following functions:

(a) monitor and evaluate the prophylactic, therapeutic and empiric use of drugs in an effort to assure that drugs are provided appropriately, safely and effectively;

(b) assist the Directors of Pharmacy in the formulation of policies and procedures relating to the selection, distribution, handling, and use and administration of drugs and diagnostic testing materials;

(c) assist the Directors of Pharmacy in the development and periodic review of a formulary or drug list for use in each Memorial Health Hospital;

(d) assist in the formulation, revision, and enforcement of policies and procedures governing the safe administration of drugs;

(e) establish guidelines and recommendations for the clinical review and statistical/prevalence study of antibiotic and other drug usage throughout Memorial Health;

(f) recommend standards regarding the use and control of investigational drugs and concerning research in the use of recognized drugs;

(g) review clinical data concerning new drugs or preparations requested for use in Memorial Health;

(h) make recommendations regarding drugs to be stocked on the nursing unit floors and by other services;

(i) establish procedures which will prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients; and

(j) make recommendations concerning drugs for which automatic stop orders are necessary.

5.O.3. Meetings, Reports, and Recommendations:

The Pharmacy and Therapeutics Committee shall meet as necessary to accomplish its functions, but at least quarterly.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet as needed.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Medical Staff President, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws, each department and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the Medical Staff President, or by a petition signed by not less than 10% of the voting members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least 14 days in advance of the meetings. The primary mechanism utilized for providing notice will be e-mail; however, notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least 14 days prior to the meetings. All notices shall provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours and posting may not be the sole mechanism used for providing notice of a special meeting.

(c) The attendance of any individual Medical Staff member at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and the Leadership Council, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for amendments to these Medical Staff Bylaws, at least 10% of the Voting Staff shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding, even if attendance drops below a quorum during the course of the meeting.

(c) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be by written ballot at the discretion of the Presiding Officer.

(d) The voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, or telephone and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws (which requires a 10% quorum) and actions by the MEC and the Leadership Council (which require a 50% quorum), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(e) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a department or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the

majority vote for that matter would be calculated as five of the remaining nine votes).

(f) At the discretion of the Presiding Officer, one or more Medical Staff members may participate in a meeting by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings, and the Presiding Officer (Medical Staff Officer, Department Chair, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of Medical Staff members and the recommendations made and the votes taken on each matter. The minutes shall be signed by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by these Bylaws or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Leadership Council is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable department and committee meetings each year.

(c) Participation at a meeting by telephone or videoconference may constitute attendance at the discretion of the Presiding Officer.

ARTICLE 7

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

7.A. QUALIFICATIONS

7.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, and/or clinical privileges and as a condition of maintaining ongoing appointment and/or clinical privileges, individuals must satisfy the applicable eligibility criteria:

(a) All Practitioners:

(1) have a current, unrestricted license to practice in Illinois that is not subject to any restrictions, conditions or probationary terms;

(2) not currently be under investigation by any state licensing agency and have never had a license to practice (either temporary or permanent) denied, revoked, restricted or suspended by any state licensing agency;

(3) where applicable to their practice, have a current, unrestricted DEA registration and state-controlled substance license and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended;

(4) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(5) not currently be under any criminal investigation indictment and have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(6) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(7) have not been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship or a similarly equivalent program for other categories of Practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(8) have not had appointment, clinical privileges, or Scope of Practice denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(9) have not resigned appointment or relinquished clinical privileges or a Scope of Practice during an Investigation or in exchange for not conducting such an Investigation;

(10) have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, violence, or the practitioner-patient relationship;

(11) have or agree to make appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed Practitioner with appropriate specialty-specific privileges as determined by the MEC) with other Practitioners for those times when the individual will be unavailable;

(12) demonstrate recent clinical activity in their primary area of practice during the last year;

(13) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

(14) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board or Memorial Health, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety; and

(15) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures).

(b) Additional Criteria for Medical Staff Members[1] (Unless Exempted Based on Medical Staff Category):

(1) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any inpatients for whom they have responsibility and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner (as determined by the MEC, taking into account historical performance at the time of reappointment). Compliance with this

[1] These criteria apply to all members unless a waiver is granted, or they are exempt based on their Medical Staff category assignment.

eligibility requirement means that the Practitioner must document that he or she is willing and able to:

(i) respond within 15 minutes, via phone, to an initial contact from the Hospital; and

(ii) appear in person to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (a) the acute nature of the patient's condition or (b) as required for a particular specialty as recommended by the MEC and approved by the Board);

(2) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the MEC) by another Practitioner with appropriate clinical privileges;

(3) if applying for clinical privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(4) have successfully completed:

(i) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges;

(ii) a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or

(iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(5) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and*

(6) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).

* The requirements pertaining to board certification are applicable to those individuals who apply for initial staff appointment after October 19, 2015 and are not applicable to Medical Staff members who were appointed prior to that date. Those Medical Staff members shall be grandfathered and shall be governed by any board certification and residency training requirements that may have been in effect at the time of their initial appointments. However, any Medical Staff member who was board certified as of the adoption date of these Bylaws is expected to maintain certification, regardless of the board certification requirements that were in effect at the time of his or her initial Appointment.

In addition, in exceptional circumstances, the five-year time frame for initial applicants and the time frame for maintenance/recertification by existing members may be extended for one additional period, not to exceed two years, in order to permit an individual an additional opportunity to obtain or maintain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(i) the individual has been on the Hospital's Medical Staff for at least two full years;

(ii) there have been no significant documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;

(iii) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

(iv) the appropriate Department Chair at the Hospital provides a favorable report concerning the individual's qualifications.

(c) Additional Criteria for APPs and LIPs:

(1) in the case of an Advanced Practice Professional, have a written collaborative/supervision agreement, as applicable, with a Supervising/Collaborating Physician, that meets all applicable requirements of state law and Hospital policy; and

(2) have completed his or her professional education and is either certified by the appropriate nationally recognized certification organization or, if he or

she is not certified, must acquire the appropriate nationally recognized professional certification at the first time certification is available. All certifications must be maintained on a continuous basis. Training and certification requirements are included in **Appendix A**; and

(3) agree to the Standards of Practice outlined in Article 13 of these Bylaws, as applicable.

7.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver shall be submitted to the MEC for consideration. In reviewing the request for a waiver, the MEC may consider the specific qualifications of the applicant in question, and the best interests of the Hospital and the communities it serves. Additionally, the MEC may, in its discretion, consider the application form and other information supplied by the applicant. The MEC's recommendation will be forwarded to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(d) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(e) An application for appointment or permission to practice that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.

7.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the assessment of the initial grant or renewal of clinical privileges at time of appointment and reappointment, as reflected in the following factors:

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

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

(c) good reputation and character;

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

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

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

7.A.4. No Entitlement to Appointment, Reappointment, or Clinical Privileges:

No individual is entitled to receive an application or to be granted appointment, reappointment, or particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff appointment, permission to practice as an Advanced Practice Professional or Licensed Independent Practitioner, or clinical privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

7.A.5. Nondiscrimination:

Neither the Hospital nor the Medical Staff will discriminate in granting Appointment, Reappointment, and/or clinical privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, age, ethnic/national identity, religion, disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

7.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

7.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment, and/or clinical privileges, and as a condition of maintaining ongoing appointment and/or clinical privileges, every Practitioner specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff and Memorial Hospital in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of his or her clinical privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);

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

(f) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leadership, or to clearly document the clinical reasons for variance;

(g) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC, Memorial Health, or required by the Board, including, but not limited to, those involving electronic

medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(h) to inform Medical Staff Services, in writing, as soon as possible, but in all cases within 10 days, of any change in the Practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request and shall include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA or state-controlled substance authorization,
- adverse changes in professional liability insurance coverage,
- the filing of a professional liability lawsuit against the Practitioner,
- changes in the Practitioner's status (appointment, permission to practice, or clinical privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
- changes in the Practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,
- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,
- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,
- any changes in the Practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy),
- any referral to a state practitioner health program, and
- any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the Practitioner Health Policy);

(i) to immediately submit to an appropriate evaluation in accordance with the Practitioner Health Policy, which may include, but is not limited to, diagnostic testing such as a blood and/or urine test, when there is the potential for imminent

danger to patients or staff or significant concerns exist regarding the individual's ability to safely and competently care for patients (all such requests will be managed in accordance with the Practitioner Health Policy);

(j) to meet with Medical Staff Leaders and/or members of the Administrative Leadership upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical Staff leaders and/or Hospital administration as may be requested;

(k) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(l) to maintain and monitor a current e-mail address (Memorial Health or Memorial Health-approved) and other Memorial Health-approved electronic communication channels (e.g., personal e-mail, secure portal, or secure text) with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff information to the Practitioner;

(m) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);

(n) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;

(o) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(p) to not deceive patients as to the identity of any individual providing treatment or services;

(q) to seek consultation whenever required or necessary;

(r) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record as required;

(s) to cooperate with all care management activities;

(t) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(u) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(v) to promptly pay any applicable dues, assessments, and/or fines;

(w) if practicing as an Advanced Practice Professional, to strictly comply with the standards of practice applicable to the functioning of Advanced Practice Professionals in the inpatient hospital setting, as set forth in Section 13.B of these Bylaws;

(x) if practicing as an Advanced Practice Professional, to refrain from deceiving patients as to the individual's status as an Advanced Practice Professional and to always wear proper Hospital identification of their name and status; and

(y) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application, with no entitlement to any hearing or appeal rights contained in these Bylaws. If the determination is made to not process an application pursuant to this provision, the individual may not reapply for a period of at least two years. If appointment and clinical privileges have been granted prior to the discovery of a misstatement or omission, an individual's appointment and clinical privileges may be deemed to be automatically relinquished by the MEC. In this situation, the individual involved would be entitled to the hearing rights contained in Section 11.E.8 of these Bylaws. If, following the hearing process, the determination that appointment and clinical privileges should be automatically relinquished pursuant to this provision stands, the individual may not reapply to the Medical Staff for a period of at least two years.

7.B.2. Burden of Providing Information:

(a) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any applicable dues or fines have been paid. An application shall become incomplete

if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 Days after the individual has been notified of the additional information required, the application will be deemed to be withdrawn and the individual may not submit another application for appointment or clinical privileges for a period of two years.

(d) The individual seeking appointment, reappointment and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

7.C. APPLICATION

7.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of these Bylaws.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the MEC or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

7.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

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

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or any of its affiliates or subsidiaries, or any of their Boards, Board members, Medical Staffs, Medical Staff members, Advanced Practice Professionals, Licensed independent Practitioners, representatives or agents, or any third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, its Medical Staff, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff and/or clinical privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes these third parties to release this information to the Hospital, its Medical Staff, Medical Staff Leaders, and their authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital, its Medical Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities,

managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Hospital that are assessing my professional qualifications, competence, or health pursuant to a review that I have been notified is occurring under applicable Hospital or Medical Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any peer review information in response to such inquiries does not waive any associated privilege, and any and all disclosures shall be made with the understanding that the receiving entity will only use such peer review information for peer review purposes.

(d) Authorization to Share Information among Memorial Health Entities:

The individual specifically authorizes Memorial Health Entities (as defined below) to share with one another any information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality, safety, necessity, and compliance with applicable law of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual. For purposes of this Section, an Memorial Health Entity means:

(1) any entity that satisfies both of the following requirements:

(i) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(ii) is directly or indirectly, through one or more intermediaries, controlled by Memorial Health. Memorial Health Entities that are "controlled by Memorial Health" for purposes of this definition include, but are not limited to, the following entities, as well as those individuals, committees, and boards who act on their behalf:

- Memorial Health and its Hospitals;
- Memorial Health urgent care centers, cancer care centers, and ambulatory surgery centers;
- any Memorial Health-affiliated physician group;
- any joint ventures in which Memorial Health has an interest of 50 percent or more;

- any entity that is managed, via a written management services agreement, by one of the entities described in this subsection (1); and

(2) any entity not included in subsection (1) that provides patient care services and that:

(i) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(ii) has appropriate provisions regarding the sharing of Confidential Information consistent with the Memorial Health Information Sharing Policy in a professional services contract or separate agreement with the Memorial Health or a Memorial Health Entity identified in subsection (1).

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff members, Advanced Practice Professionals, Licensed Independent Practitioners, authorized representatives, agents, and employees who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 7.C.2 are applicable in the following situations:

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

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

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

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or no longer practices as an Advanced Practice Professional or Licensed Independent Practitioner about his or her tenure at the Hospital; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 8

PROCEDURE FOR INITIAL APPOINTMENT

8.A. PROCEDURE FOR INITIAL APPOINTMENT

8.A.1. Request for Application:

(a) Applications for appointment will be on approved forms or submitted through an approved Hospital portal/website.

(b) An individual seeking initial appointment will be sent information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in these Bylaws, (ii) outlines the applicable criteria for any clinical privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final six months of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

8.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services.

(b) As a preliminary step, the application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in these Bylaws and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) Medical Staff Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

8.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from peer references (from the same discipline where practicable) and from other available sources, including the

applicant's past or current Department Chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The review process described in this Article will also be guided by Age Consideration Policy.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the Department Chair, the MEC, the Medical Staff President, the CMO, and/or the CEO. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

8.A.4. Department Chair and Chief Nursing Officer Procedure:

(a) Medical Staff Services shall transmit the complete application and all supporting materials to the relevant Department Chair(s) (or a designated Advanced Practice Professional for the review of APP applications) in which the applicant seeks clinical privileges. The Department Chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by Medical Staff Services.

(b) In addition to review by the Department Chair, all Practitioners who are seeking clinical privileges to practice as advanced practice nurses shall also be evaluated by the Chief Nursing Officer (or designee).

(c) The Department Chair (or designated Advanced Practice Professional) shall be available to the MEC and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

8.A.5. MEC Procedure:

(a) The MEC shall review and consider the report prepared by the relevant Department Chair (or designated Advanced Practice Professional) and, when relevant, the Chief Nursing Officer, and shall make a recommendation.

(b) The MEC may use the expertise of any member of the Medical Staff, an Advanced Practice Professional (if applicable), or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the MEC may require the applicant to provide information regarding his or her health status and/or to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the MEC if there is any question about the applicant's ability to perform the clinical privileges requested and the responsibilities of appointment. The results of this examination shall be made

available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the MEC shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The MEC may recommend specific conditions on appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The MEC may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 12.A.1(a) or Section 13.F.2 of these Bylaws, as pertinent, such conditions do not entitle an individual to request the procedural rights set forth in Article 12 or Article 13 of these Bylaws.

(e) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(f) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 12.A.1(a) or Section 13.F.2 of these Bylaws, as pertinent, the MEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

8.A.6. Board Action:

(a) Expedited Review: The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or clinical privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) Full Board Review: When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the MEC or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

8.A.7. Time Periods for Processing:

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

8.A.8. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to these Bylaws shall be for a duration of not more than two years.

8.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 9

CLINICAL PRIVILEGES

9.A. CLINICAL PRIVILEGES

9.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each Practitioner who has been granted appointment is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) For requests for clinical privileges to be processed, all threshold criteria applicable to the clinical privileges being requested must be satisfied.

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

(d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 9.A.2).

(e) The clinical privileges recommended to the Board shall be based on consideration of the following factors:

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

(2) appropriateness of utilization patterns;

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

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of other qualified staff members with appropriate privileges (as determined by the MEC) to provide coverage in case of the applicant's illness or unavailability;

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

(7) the Hospital's available resources and personnel;

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

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

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

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

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

(f) Core privileges, special privileges, clinical privilege delineations, and/or the criteria for the same shall be developed for review by the MEC, which will forward its recommendations to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(h) The report of the Department Chair(s) in which clinical privileges are sought shall be processed as a part of the initial application for staff appointment.

9.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff or as an Advanced Practice Professional or Licensed Independent Practitioner, and waivers related to eligibility criteria for clinical privileges or the scope of those privileges.

(b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing or electronically to Medical Staff Services.

(c) Increased Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question. All such requests shall be processed in accordance with Section 7.A.2 of these Bylaws. In addition to the factors defined in Section 7.A.2, the Medical Staff leadership may also consider the additional factors set forth in Section 9.A.2(f) in considering all such requests.

(2) If the individual is requesting a waiver of the requirement that each individual apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.

(i) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services within the core that the Practitioner does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) Review Process: A request for a waiver shall be submitted to the MEC for consideration. In reviewing the request for a waiver, the MEC shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant Department Chair. The MEC shall make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(iii) On-Call Obligations: By applying for a waiver related to limiting the scope of core privileges, the Medical Staff member nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other members of the Medical Staff in assessing and stabilizing patients

who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other Medical Staff members in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:

(i) completion of all medical records;

(ii) as applicable, the appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) as applicable, the completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the Medical Staff President, the CEO will act on the resignation request with a report on the matter forwarded to the MEC. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to core privileges:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed on the individual;

(4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a Practitioner to request privilege modifications or waivers in accordance with this Section shall, as applicable, result in the Practitioner retaining appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

9.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital, and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.

(b) As an initial step in the process, the Practitioner seeking to perform the new procedure will prepare and submit a report to the CMO addressing the following:

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

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

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

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

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

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

Hospital administration shall review this report and consult with the Medical Staff President and the Department Chair (any of whom may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the Hospital is favorable, the MEC will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a "new procedure," the MEC will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the MEC may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the procedure or service;

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

(3) the manner of addressing the most common complications that may arise in the performance of the new procedure;

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

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) The MEC will forward its recommendations to the Board for final action.

(e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to perform the procedure or service may be processed.

9.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the Practitioner seeking the privilege will prepare and submit a report to the MEC that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care. The Administrative Leadership will confirm the request is permissible under any existing exclusive contracts or Board directives regarding a closed service that are in place at the Hospital before the request is forwarded to the MEC.

(c) The MEC shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The MEC may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the committee may develop recommendations regarding:

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

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

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

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

(5) the impact, if any, on emergency call responsibilities.

(e) The MEC shall forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to exercise the privileges in question may be processed.

9.A.5. Clinical Privileges for Dentists:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), Dentists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the MEC. They must, nevertheless, have a relationship with a Physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a qualified Practitioner who has been granted clinical privileges to complete medical histories and physical examinations before dental surgery may be performed. In addition, a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The Dentist shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists may write orders within the scope of their licenses and consistent with relevant Hospital policies and Rules and Regulations.

9.A.6. Clinical Privileges for Podiatrists:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), Podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the MEC. They must, nevertheless, have a relationship with a Physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a qualified Practitioner who has been granted clinical privileges to complete medical histories and physical examinations before podiatric surgery may be performed. In addition, a designated Physician member of the Medical Staff shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The Podiatrist shall be responsible for the podiatric surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Podiatrists may write orders within the scope of their licenses and consistent with relevant Hospital policies and Rules and Regulations.

9.A.7. Physicians in Training:

(a) Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in these Bylaws have been met. Requests for such clinical privileges shall be reviewed in accordance with the initial credentialing process outlined in these Bylaws and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may only be granted clinical privileges in those areas for which they can demonstrate current clinical competence.

9.A.8. Telemedicine Privileges for Distant-Site Practitioners:

(a) A qualified individual providing services from a distant-site location may be granted telemedicine privileges regardless of whether the individual is Appointed to the Medical Staff.

(b) Requests for initial or renewed telemedicine privileges by distant-site Practitioners will be processed through one of the following options, as determined by the CEO in consultation with the Medical Staff President:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such case, the distant-site Practitioner must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to response times, coverage arrangements, and emergency call responsibilities.

(2) If the distant-site Practitioner is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the distant-site Practitioner is licensed in Illinois;

(ii) a current list of clinical privileges granted to the distant-site Practitioner;

(iii) information indicating that the distant-site Practitioner has actively exercised the relevant clinical privileges during the previous 12 months and has done so in a competent manner;

(iv) confirmation that the distant-site Practitioner satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) confirmation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other confirmation, attestations, or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that a distant-site Practitioner is ineligible for appointment or clinical privileges if the individual fails to satisfy the threshold eligibility criteria set forth in these Bylaws.

(c) Telemedicine privileges, if granted, shall be for a period of not more than two years.

(d) Distant-site Practitioners who have been granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the distant-site Practitioner by patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

9.B. TEMPORARY CLINICAL PRIVILEGES

9.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Medical Staff President, after considering the evaluation of the Department Chair; and

(5) temporary privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The CEO may grant temporary privileges to an individual serving as a locum tenens for a Practitioner who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous year), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the applicant has received a favorable recommendation from the Medical Staff President, after considering the evaluation of the Department Chair;

(5) the applicant will be subject to any focused professional practice requirements established by the Hospital; and

(6) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 10 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

The review process described in this Section will also be guided by Age Consideration Policy.

(c) Visiting. The CEO, upon recommendation of the Medical Staff President and the applicable Department Chair, may also grant temporary privileges in other limited situations when there is an important patient care, treatment, or service need, under the following circumstances:

(1) the temporary privileges are needed (i) for the care of a specific patient; (ii) when a proctoring or consulting Practitioner is needed, but is otherwise unavailable; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area;

(2) the following factors are considered and/or verified prior to the granting of temporary privileges: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of clinical privileges in these situations will not exceed 60 days; however, in exceptional situations, this period of time may be extended in the discretion of the CEO and the Medical Staff President.

Any individual seeking visiting temporary privileges who is currently appointed in good standing to another Memorial Health Hospital with a grant of clinical privileges relevant to the request for visiting privileges shall be immediately authorized to exercise visiting privileges upon verification of good standing by Medical Staff Services and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges.

(d) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary privileges by the relevant Department Chair, the Medical Staff President, and the CEO.

(e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(f) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

9.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

9.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The CEO may withdraw temporary admitting privileges at any time, after consulting with the Medical Staff President, the Department Chair, or the CMO. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the Department Chair, the Medical Staff President, or the CMO may immediately withdraw all temporary privileges. The Department Chair or the Medical Staff President shall assign to another Practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

9.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a Practitioner may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the Department Chair or the Medical Staff President to a member with appropriate clinical privileges, considering the wishes of the patient.

9.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the CMO, or the Medical Staff President may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

9.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. The Board may accomplish this by (i) entering into an exclusive contract that confers the exclusive right to perform specified services to one or more members or groups of members, or (ii) passing a Board resolution that would limit the members who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of these Bylaws.

(2) MEC Review. Prior to the Hospital signing an exclusive contract or passing any Board resolution as described above in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Medical Staff President) will review the quality of care and service implications of the proposed exclusive contract or Board resolution and provide a report of its findings and recommendations to the Board within 30 days of the Board's request.

As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(3) Notice and Hearing Procedures. After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and hearing procedures:

(a) The affected member shall be given at least 60 days' advance notice of the exclusive contract or Board resolution. The notice shall inform the member of the right to request a hearing as set forth in this Section prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.

(b) The affected member must request the hearing within 14 days of receiving the notice, and the hearing must then be commenced and concluded within 30 days of the member's request (unless the individual and the Board agree upon a different time frame/schedule). A report and recommendation must be prepared by the hearing committee within this 30-day period and copies sent to the affected member, the Board, and the MEC.

(c) The hearing shall be held before a committee appointed by the Board, which shall include representatives from the MEC. At the hearing, the affected member shall be entitled to present any information and documentation that he deems relevant to the Board's decision to enter into the exclusive contract or enact the resolution, as well as to present witnesses in support of his position.

(d) An affected member may be represented by counsel at the hearing, but must notify the Hospital of that fact at the time that the hearing is requested. If the affected member chooses to be accompanied by counsel, the Board's representative shall also be represented by legal counsel at the hearing. If an affected member chooses not to be represented by counsel at the hearing, the Board representative shall not have legal counsel present. In addition, the hearing committee itself may select an attorney to assist it in conducting an orderly and fair hearing and in the preparation of the committee's report and recommendation.

(e) Following receipt of the hearing committee's report and recommendation, the Board shall make a final decision in the matter. If the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(f) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his clinical privileges, notwithstanding the provisions in Article 12 of these Bylaws.

(g) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Illinois licensure board or to the National Practitioner Data Bank.

(4) Except as provided in paragraph (1), in the event of any conflict between these Bylaws and the terms of any contract, the terms of the contract shall control. In particular, nothing in this Section shall preclude or limit a Medical Staff member's right to waive, in writing, his right to request a hearing upon being granted the exclusive right to provide particular services at the Hospital, either individually or as a member of a group. If any exclusive contract is signed by a representative of a group of physicians, any waiver that is contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

ARTICLE 10

PROCEDURE FOR REAPPOINTMENT

10.A. PROCEDURE FOR REAPPOINTMENT

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

10.A.1. Eligibility for Reappointment:

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

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

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

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 7.A.1 of these Bylaws;

(e) if applying for renewal of clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer) before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fee, if any.

10.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 7.A.3 of these Bylaws will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

10.A.3. Reappointment Application:

(a) An application for reappointment shall be made available to Practitioners at least five months prior to the expiration of their current appointment term. A completed reappointment application must be submitted to Medical Staff Services within 60 days of receipt.

(b) Failure to submit a complete application at least three months prior to the expiration of the Practitioner's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Article 8.

(c) Reappointment shall be for a period of not more than two years.

(d) The application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) Medical Staff Services shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

10.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services shall forward the application to the relevant Department Chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

10.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent on a Practitioner's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 12.A.1(a) or Section 13.F.2 of these Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 12 or Article 13 of these Bylaws, as applicable.

(b) reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 12 or Article 13, as applicable.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal Investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

10.A.6. Potential Adverse Recommendation:

(a) If the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the chair will notify the Practitioner of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the Practitioner will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the Practitioner will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the MEC's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The Practitioner will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

(e) If the Board determines to reject a favorable recommendation from the MEC, it should first discuss the matter with the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send a Special Notice to the applicant that the applicant is entitled to request a hearing under these Bylaws.

10.A.7. Time Periods for Processing:

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

10.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 11

QUESTIONS INVOLVING PRACTITIONERS

11.A. INITIAL MENTORING EFFORTS AND PROGRESSIVE STEPS

(1) These Bylaws encourage the use of initial mentoring efforts and Progressive Steps by Medical Staff Leaders and Administrative Leadership to address questions relating to a Practitioner's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised. Medical Staff Leaders and members of the Administrative Leadership have been authorized by the MEC and the Leadership Council to engage in initial Mentoring Efforts and Progressive Steps and all of these activities are undertaken on behalf of these committees as part of their professional practice evaluation functions.

(2) Initial Mentoring Efforts include activities such as:

(a) informal discussions or coaching by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

There is no requirement that these efforts be documented, though brief documentation is encouraged to help determine if a pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's confidential file.

(3) Progressive Steps are defined as follows:

(a) addressing minor performance issues through Informational Letters;

(b) sending an Educational Letter that describes opportunities for improvement and provides specific guidance and suggestions;

(c) facilitating formal Collegial Counseling (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Voluntary Enhancement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

All Progressive Steps shall be documented in a constructive manner and included in an individual's confidential file. Any written responses to any of these Progressive Steps by the individual shall also be included in the individual's confidential file.

(4) All of these efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.

(5) Initial Mentoring Efforts and Progressive Steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and the Administrative Leadership. When a question arises, the Medical Staff Leaders and/or Administrative Leadership may:

(a) address it pursuant to the initial Mentoring Efforts and Progressive Steps provisions of this Section;

(b) refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy; or

(c) refer it to the MEC for its review and consideration in accordance with Section 11.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with these Bylaws, the individual is entitled to be accompanied by legal counsel at that hearing. However, Practitioners do not have the right to be accompanied by counsel when the Medical Staff Leaders and members of the Administrative Leadership are engaged in Initial Mentoring Efforts or other Progressive Steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve Initial Mentoring Efforts or Progressive Steps activities.

11.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy. Matters that are not satisfactorily resolved through initial Mentoring Efforts or other Progressive Steps or through one of these policies shall be referred to the MEC for its review in accordance with Section 11.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

11.C. REQUEST TO REFRAIN FROM PRACTICING/PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

11.C.1. Grounds for Requests to Voluntarily Refrain/Precautionary Suspension or Restriction:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any Medical Staff Officer or relevant Department Chair, acting in conjunction with the CEO or the CMO, shall have the authority to proceed as follows:

(1) request that the Practitioner agree to voluntarily refrain from exercising privileges pending further review of the circumstances by the Leadership Council in accordance with Section 11.C.2 of these Bylaws (agreements to voluntarily refrain may also be utilized in other professional practice evaluation contexts such as voluntary enhancement plans, the details of which are addressed in the relevant professional practice evaluation policy); or

(2) if the Practitioner is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's clinical privileges as a precaution, which actions shall be reviewed by the MEC in accordance with Section 11.C.3 of these Bylaws.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

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

(d) These actions shall become effective immediately, shall promptly be reported in writing to the CEO, the CMO, and the Medical Staff President, and shall remain in effect unless the action is modified by the CEO or MEC.

(e) The Practitioner shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), and shall be provided to the Practitioner within three days of the action.

11.C.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in a Practitioner's agreement to voluntarily refrain from exercising clinical privileges within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the Practitioner shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate a formal Investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

11.C.3. MEC Review Process for Precautionary Suspensions or Restrictions:

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

(b) Scope of Hearing. The scope of any such hearing shall be limited to the appropriateness of imposing, and the need to continue, the precautionary suspension under the circumstances. At the hearing, the Practitioner will be given an opportunity to personally discuss the matter with the MEC, provide additional information and documentation, and present witnesses to support his or her position. The individual may also propose ways other than a precautionary suspension or restriction to protect patients and other individuals. The individual may be represented by counsel at the hearing but must notify the Hospital of that fact at the time that the hearing is requested. If the individual chooses to be accompanied by counsel, the MEC shall also be represented by legal counsel at the

hearing. If the individual chooses not to be represented by counsel at the hearing, the MEC shall not have legal counsel present. No recording (audio or video) or transcript of the hearing shall be permitted or made; however, minutes of the hearing shall be prepared.

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

(1) Affirmed. The MEC may affirm the precautionary suspension or restriction pending completion of a formal Investigation pursuant to Section 11.D of these Bylaws. If, following the formal Investigation, the MEC makes another recommendation that would entitle the practitioner to a hearing under Section 12.A.1(a) or Section 13.F.2 of these Bylaws (as applicable), the Practitioner may request such a hearing and it will be conducted in accordance with the provisions of Article 12 or Article 13.

(2) Lifted, Expunged, or Modified. If the MEC determines that the precautionary suspension or restriction should be lifted, expunged, or modified, this decision shall take effect immediately. The MEC shall then take whatever next steps are appropriate under the circumstances, which could include still proceeding with a formal Investigation pursuant to Section 11.D of these Bylaws. The Board (or a committee of the Board) shall review the MEC's determination to lift, expunge, or modify the suspension or restriction on an expedited basis. If the Board (or committee) disagrees with the determination of the MEC, representatives of the Board and the MEC shall meet to discuss the matter and determine appropriate next steps.

11.C.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the Department Chair or the Medical Staff President shall assign to another Practitioner with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or to otherwise aid in implementing the precautionary suspension, restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician but may not always be accommodated.

(b) All Practitioners have a duty to cooperate with the Medical Staff President, the Department Chair, the MEC, the CMO, and the CEO in enforcing precautionary suspensions or restrictions or agreements to voluntarily refrain from practicing.

11.D. INVESTIGATIONS

11.D.1. Initial Review:

(a) Where initial Mentoring Efforts or other Progressive Steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Hospital or the Medical Staff; and/or

(4) conduct by any Practitioner that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others,

the matter may be referred to the Medical Staff President, the relevant Department Chair, the chair of a standing committee, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Practitioner, the matter shall be referred to the Medical Staff President, the relevant Department Chair, the chair of a standing committee, or the CEO for review and appropriate action in accordance with these Bylaws.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an Investigation.

11.D.2. Initiation of Investigation:

(a) When a question involving a Practitioner's clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an Investigation, to direct the matter to be handled

pursuant to another policy (e.g., Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy), or to proceed in another manner. Prior to making its determination, the MEC may discuss the matter with the individual. An Investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an Investigation has begun. The notification shall include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

(3) a statement that the physician will be given the opportunity to meet with the committee conducting the Investigation before the Investigation concludes; and

(4) a copy of Section 11.D.3 of these Bylaws, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or Medical Staff.

11.D.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 14. Any ad hoc committee may include individuals not on the Medical Staff or affiliated as Advanced Practice Professionals or Licensed Independent Practitioners. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, oral surgeon, or relevant discipline of Advanced Practice Professional or Licensed Independent Practitioner).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary,

which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Investigation shall be notified of that decision and the nature of the external review. However, the individual under Investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

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

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the

Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of the commencement of the Investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee shall prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

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

(i) relevant literature and clinical practice guidelines, as appropriate;

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

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

11.D.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension or Restriction of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) If a recommendation by the MEC would entitle the individual to request a hearing in accordance with Section 12.A.1 or Section 13.F.2, as applicable, the recommendation will be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) A determination by the MEC that does not entitle the individual to request a hearing will take effect immediately. All such determinations shall be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(d) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

11.E. AUTOMATIC RELINQUISHMENT/ACTIONS

11.E.1. General:

An automatic relinquishment is considered an administrative action that occurs by operation of these Bylaws. As such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank or any state licensing agency and shall take effect without hearing or appeal in accordance with Article 12. Rather, an individual who is subject to an automatic relinquishment may request a hearing as described in Section 11.E.8 of these Bylaws.

11.E.2. Failure to Satisfy Threshold Eligibility Criteria:

(a) An individual's appointment and clinical privileges shall be automatically relinquished if the individual fails to continuously satisfy any of the threshold eligibility criteria set forth in these Bylaws (except for board certification, which shall be assessed at the time of reappointment). These eligibility criteria are set forth in Sections 7.A.1 and 10.A.1 of these Bylaws and include, but are not limited to, the maintenance of an unrestricted license, compliance with any health screening requirements, fulfillment of all emergency service call obligations, no disciplinary actions taken by another hospital, and any criteria specific to an Advance Practice Professional.

(b) In addition to the above, an individual's appointment and clinical privileges shall be automatically relinquished if the individual is arrested, charged, or indicted for any felony or for any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, or (vii) the practitioner-patient relationship.

(c) Automatic relinquishment shall take effect immediately upon written notice to the individual and shall continue until the matter is resolved and the individual is granted reinstatement.

(d) If the underlying matter leading to automatic relinquishment is resolved within 60 days (i.e., the individual demonstrates he or she meets all applicable eligibility criteria or is granted a waiver regarding the eligibility criteria in question in accordance with Section 7.A.2), the individual may be reinstated in accordance with Section 11.E.7. In addition, if an arrest, charge or indictment as defined above has not been fully resolved within the 60-day time period, an individual may request

reinstatement but bears the burden of demonstrating, in the full discretion of the Leadership Council, that the underlying matter does not raise concerns about the individual's professional qualifications and/or ability to completely and safely exercise clinical privileges.

(e) Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation of appointment and clinical privileges

11.E.3. Failure to Provide Required Notification to Medical Staff Services:

(a) Practitioners must notify Medical Staff Services, in writing, within 10 days of the occurrence of any of the following events:

(1) changes in the Practitioner's licensure status or DEA or state-controlled substance authorization;

(2) changes in the Practitioner's appointment or clinical privileges at another hospital or health care facility because of issues related to clinical competence or professional conduct, including the Practitioner's resignation while under investigation;

(3) changes in the Practitioner's employment status at any medical group or hospital because of issues related to clinical competence or professional conduct;

(4) the Practitioner's arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter (other than a misdemeanor traffic citation);

(5) the Practitioner's exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

(6) any changes in the Practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues;

(7) the Practitioner's participation in a state practitioner health program; and

(8) any charge of, or arrest for, driving under the influence ("DUI").

Failure of a Practitioner to provide this notification shall result in the automatic relinquishment of appointment and clinical privileges.

(b) When an automatic relinquishment occurs under this Section 11.E.3, the Practitioner will be given the opportunity to submit a written response for the Leadership Council's consideration. The relinquishment shall remain in effect

unless the Leadership Council determines, in its sole discretion, that the Practitioner has provided a satisfactory explanation and has eliminated any concern regarding the failure to provide the required notification. If the Leadership Council makes this determination, the Practitioner's appointment and clinical privileges will be reinstated upon the Leadership Council's receipt of any additional information or documentation regarding the issue that may be requested by the Leadership Council.

(c) If the Leadership Council determines that the Practitioner has failed to provide a satisfactory explanation and eliminate the concerns, the appointment and clinical privileges shall be automatically resigned.

11.E.4. Failure to Complete Medical Records:

Failure to complete medical records, after notification by the medical records department of delinquency, may result in automatic relinquishment of all clinical privileges in accordance with the time frames as set forth in the Hospital's Delinquent Medical Record Policy (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

11.E.5. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for continued appointment or clinical privileges, in response to a written request from the MEC, the Leadership Council, the CMO, the CEO, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation of appointment and clinical privileges.

11.E.6. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any Practitioner, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders, one or more members of the Administrative Leadership, and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The notice to the individual regarding this meeting shall be given in writing at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation of appointment and clinical privileges.

11.E.7. Request for Reinstatement:

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

(b) Requests for reinstatement following the relinquishment of clinical privileges due to medical record delinquencies will be accomplished in accordance with applicable medical record policies and/or rules and regulations.

(c) Requests for reinstatement following the relinquishment of clinical privileges due to failure to provide requested information and/or failure to attend a special meeting shall be reviewed by the Leadership Council Chair. If the Leadership Council Chair recommends favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the full Leadership Council in accordance with (d) below.

(d) All other requests for reinstatement following a relinquishment of clinical privileges shall be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. If, however, the Leadership Council has any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the MEC and Board for review and recommendation.

11.E.8. Hearings Regarding Automatic Relinquishments:

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

(b) The individual may be represented by counsel at the hearing but must notify the Hospital of that fact at the time that the hearing is requested. If the individual chooses to be accompanied by counsel, the MEC shall also be represented by legal counsel at the hearing. If the individual chooses not to be represented by counsel at the hearing, the MEC shall not have legal counsel present.

(c) The hearing shall be governed exclusively by this Section 11.E.8. The provisions of Article 12 or Article 13 of these Bylaws shall not apply to hearings related to automatic relinquishments of appointment and/or clinical privileges.

(d) The scope of the hearing shall be limited to demonstrating that the event that led to the automatic relinquishment did not occur or that there was an extraordinary and unique circumstance that justified the event. At the hearing, the individual will be given an opportunity to personally discuss the matter with the MEC, provide additional information and documentation, and present witnesses to support his or her position. The decision of the MEC following the hearing shall be final, subject to the approval of the Board, with no right of further appeal.

11.F. LEAVES OF ABSENCE

11.F.1. Initiation:

(a) A Practitioner may request a leave of absence by submitting a written request to Medical Staff Services. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(b) The CMO shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CMO shall consult with the Medical Staff President and the relevant Department Chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Leaves for Health Issues. Except for maternity leaves, Practitioners must report to the CMO any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances (whether by report of the Practitioner or otherwise), the CEO and/or CMO, in consultation with the Medical Staff President, may trigger an automatic medical leave of absence at any point after becoming aware of the Practitioner's absence from patient care. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been enacted.

11.F.2. Duties of a Practitioner on Leave:

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

11.F.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the MEC and Board for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested and the request for reinstatement shall be processed in accordance with the Practitioner Health Policy.

(c) Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of appointment and clinical privileges.

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

11.G. ACTION AT ANOTHER MEMORIAL HEALTH HOSPITAL

(1) Each Memorial Health Hospital will share information regarding the implementation or occurrence of any of the following actions with all other Memorial Health Hospitals at which an individual maintains appointment, clinical privileges, or any other permission to care for patients:

(a) ***automatic relinquishment or resignation*** of appointment or clinical privileges for failure to meet any threshold eligibility criteria or for any of the other occurrences set forth in Section 11.E.2 of these Bylaws;

(b) ***voluntary agreement to modify clinical privileges*** or ***to refrain from exercising*** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;

(c) any ***denial, suspension, revocation, or termination*** of appointment and/or clinical privileges;

(d) participation in a ***Voluntary Enhancement Plan*** under the Professional Practice Evaluation Policy or Medical Staff Professionalism Policy;

(e) a grant of ***conditional appointment or clinical privileges*** (either at initial appointment or reappointment), or conditional continued appointment or clinical privileges; and/or

(f) any other event which, in the sole discretion of the Memorial Health Hospital making the notification, raises a ***significant concern about the Practitioner's clinical competence, professional conduct, health/ability to safely practice, or utilization practices*** in accordance with the Memorial Health Information Sharing Policy.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) (a), (b), or (c) above have occurred at any Memorial Health Hospital, that action will either:

(a) automatically and immediately take effect at the Memorial Health Hospital receiving the notice; or

(b) be cause for the Memorial Health Hospital receiving the notice to determine that the individual no longer satisfies the eligibility criteria set forth in these Bylaws and has therefore automatically relinquished his or her appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural rights (including advance notice, additional peer review, formal Investigation, hearing, or appeal) other than what occurred at the Memorial Health Hospital taking

the original action. All other information that is shared pursuant to Paragraph (1) above will be reviewed by Medical Staff Leaders at the receiving Memorial Health Hospital to determine whether additional steps may be necessary.

(3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving Memorial Health Hospital. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

(a) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or Hospital operations; and

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Memorial Health Hospital where the action first occurred. The burden is on the affected practitioner to provide evidence showing that a waiver is appropriate.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal Investigation, hearing, or appeal.

ARTICLE 12

HEARING AND APPEAL PROCEDURES FOR MEDICAL STAFF MEMBERS

The hearing and appeal procedures in this Article are only applicable to Medical Staff members and are **not** applicable to Advanced Practice Professionals or Licensed Independent Practitioners. The due process rights for Advanced Practice Professionals and Licensed Independent Practitioners are set forth in Article 13 of these Bylaws.

12.A. INITIATION OF HEARING

12.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges, whether at the time of initial appointment, reappointment, or during the course of appointment;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension which entitles an individual to the procedures outlined in Section 11.C.3 of these Bylaws, which are deemed fair under the circumstances);

(7) a Restriction of clinical privileges for more than 30 days; or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

12.A.2. Actions Not Grounds for Hearing:

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

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

(b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) determination that an applicant for clinical privileges fails to meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

(e) determination that an application shall not be processed due to a misstatement or omission;

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(h) issuance of an Informational Letter, Educational Letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Voluntary Enhancement Plan;

(l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an Investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

(o) Restriction or suspension of clinical privileges for less than 30 days;

(p) precautionary suspension;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

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

(s) removal from the on-call roster or any other reading panel;

(t) withdrawal of temporary privileges;

(u) requirement to appear for a special meeting;

(v) termination of any contract with or employment by the Hospital; and

(w) any other action that is not specifically listed in Section 12.A.1(a).

12.B. THE HEARING

12.B.1. Notice of Recommendation:

The CEO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

12.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the CEO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

12.B.3. Notice of Hearing and Statement of Reasons:

(a) The CEO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

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

(2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

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

12.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

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

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.

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

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 14 of these Bylaws.

(b) Presiding Officer:

(1) The CEO, after consulting with the Medical Staff President, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence; and

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

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

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Medical Staff President, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Medical Staff President and must include the basis for the objection. The Medical Staff President shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may participate in any such compensation should the individual wish to do so.

12.B.5. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

12.C. PRE-HEARING PROCEDURES

12.C.1. General Procedures:

(a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

(d) The hearing shall last no more than 15 hours, with each side being afforded approximately seven and one-half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

12.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

(a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

12.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

12.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information shall not waive any privilege under the state peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

12.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no

later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and shall resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

12.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

12.C.7. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

12.D. HEARING PROCEDURES

12.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(2) to introduce exhibits;

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

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

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

12.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

12.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

12.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

12.D.5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the Medical Staff President, and the CEO. In addition, administrative personnel may be present as requested by the CEO or the Medical Staff President.

12.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

12.D.7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

12.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

12.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone but shall be permitted only by the Presiding Officer or the CEO on a showing of good cause.

12.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

12.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

12.E.2. Deliberations and Recommendation of the Hearing Panel:

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

12.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MEC.

12.F. APPEAL PROCEDURE

12.F.1. Time for Appeal:

(a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

12.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with these Bylaws during the hearing, so as to deny a fair hearing; and/or

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

12.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

12.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

12.G. BOARD ACTION

12.G.1. Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the

Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

12.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

12.G.3. Adverse Decisions/Economic Factors:

(a) If an adverse final decision by the Board is based substantially on economic factors, the affected member shall be given 15 calendar days' notice prior to the implementation of the decision.

(b) Every such decision shall also be reported to the Hospital Licensing Board before the decision takes effect.

12.G.4. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter.

ARTICLE 13

CONDITIONS OF PRACTICE AND DUE PROCESS RIGHTS
FOR ADVANCED PRACTICE PROFESSIONALS AND
LICENSED INDEPENDENT PRACTITIONERS

13.A. RIGHTS AND PREROGATIVES

(1) Advanced Practice Professionals and Licensed Independent Practitioners shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment. The rights and prerogatives of Advanced Practice Professionals and Licensed Independent Practitioners are as set forth in this Section.

(2) Advanced Practice Professionals and Licensed Independent Practitioners may attend meetings of the Medical Staff and of relevant clinical departments, without vote.

(3) The Leadership Council shall appoint one Advanced Practice Professional to the MEC, all with vote.

(4) Advanced Practice Professionals and Licensed Independent Practitioners may be appointed to serve on other Medical Staff committees, in the discretion of the Leadership Council, also with vote.

13.B. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ADVANCED PRACTICE PROFESSIONALS IN THE INPATIENT SETTING

(1) Advanced Practice Professionals are permitted to function in the inpatient Hospital setting in collaboration with and under the Supervision and oversight of the Supervising/Collaborating Physician. As a condition of being granted appointment, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Advanced Practice Professionals in the Hospital, all Medical Staff members who serve as Supervising/Collaborating Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice apply to the functioning of Advanced Practice Professionals ("APPs") in the inpatient Hospital setting:

(a) Exercise of Clinical Privileges.

(i) APPs: APPs may exercise those clinical privileges that have been granted to them pursuant to their approved delineation of clinical

privileges. The delineation of privileges will specify the requisite levels of supervision that apply to an APP's privileges (general, direct, or personal).

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians must be available by phone, email, or other modality to respond in a timely manner to the APP or to others caring for the patient. The Supervising/Collaborating Physicians are only required to be physically present with an APP when the APP's privileges require "personal" supervision.

(b) Admitting Privileges.

(i) APPs: APPs are not granted inpatient admitting privileges and may not admit patients independently. However, APPs may examine the patient, gather data, order tests, and generate other documentation to help facilitate a patient's admission. They may also write inpatient admission orders on behalf of their Supervising/Collaborating Physicians.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians must review and co-sign all admission orders made by an APP on their behalf. (***Note***: Additional guidance regarding the responsibilities of the Admitting Physician are set forth in the Medical Staff Rules and Regulations.)

(c) Consultations.

(i) APPs: APPs may respond to consultation requests directed to their Supervising/Collaborating Physicians by examining the patients, gathering data, ordering tests, generating documentation, and then discussing the patients with their Supervising/Collaborating Physicians. They may not, however, provide consultations independently and in lieu of the Supervising/Collaborating Physicians.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians must in all cases review the APPs' documentation, assess the patients personally, and render the consultations. (***Note***: Additional guidance regarding the process for requesting consultations, when there must be personal contact with the consulting physician, and the time frames for the various types of consult requests (i.e., emergency, urgent, or routine) are set forth in the Medical Staff Rules and Regulations.)

(d) Emergency On-Call Coverage.

(i) APPs: APPs may not be listed on the emergency on-call roster (formally, or informally by agreement with their Supervising/ Collaborating Physicians). However, APPs may examine the patient, gather data, order tests, and generate other documentation regarding the patient as follows:

- When contacted directly by Emergency Department personnel and requested to do so; or

- When requested by their Supervising/Collaborating Physician after the Supervising/Collaborating Physician has discussed the patient with Emergency Department personnel.

(ii) Emergency Department Personnel: It shall be within the sole discretion of the Emergency Department personnel caring for the patient whether it is appropriate to contact an APP prior to contacting the Supervising/Collaborating Physician. If it is not deemed appropriate, the Emergency Department personnel will directly discuss the patient with the Supervising/Collaborating Physician and reach agreement regarding the patient's care, including the role of the APP in that care.

(iii) Supervising/Collaborating Physicians: Supervising/Collaborating physicians (or their covering physicians) must personally respond to all calls specifically directed to them in a timely manner, in accordance with the requirements set forth in these Bylaws. They must also personally assess any patient when requested to do so by an Emergency Department physician.

(e) Calls Regarding Supervising/Collaborating Physician's Hospitalized Inpatients.

(i) APPs: APPs may generally respond to Hospital personnel seeking assistance with the Supervising/Collaborating Physicians' hospitalized inpatients. However, APPs may not independently respond to calls from the floor or special care units that were specifically directed to the Supervising/Collaborating Physicians.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians must personally respond in a timely manner to all calls from the floor or special care units that have been specifically directed to them.

(f) Daily Inpatient Rounds for Attending Physicians.

(i) APPs: APPs are permitted to perform daily inpatient rounds and discuss patients with the patients' Attending Physician (i.e., their Supervising/Collaborating Physician).

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians who are designated as an Attending Physician must also visit the patient on a daily basis. The expectation is all such visits will occur in person, unless the MEC approves the use of telemedicine to perform the visit and evaluation.

Exceptions to the above Standards of Practice may be granted by the MEC for specific clinical situations and services, upon demonstration of good cause shown. When the MEC grants such an exception, the committee will follow the same process as set forth in Section 7.A.2 of these Bylaws.

13.C. OVERSIGHT BY SUPERVISING PHYSICIAN

(1) Any activities permitted to be performed at the Hospital by an Advanced Practice Professional or Allied Health Professional shall be performed only in collaboration with or under the supervision or direction of a Supervising/Collaborating Physician.

(2) Advanced Practice Professionals and Allied Health Professionals may function in the Hospital only so long as (i) they are supervised by a Supervising/Collaborating Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision or collaboration agreement with the Supervising/Collaborating Physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising/Collaborating Physician be revoked or terminated, the clinical privileges of the Advanced Practice Professional or the Scope of Practice of the Allied Health Professional shall be automatically relinquished (unless the individual will be supervised by another Practitioner appointed to the Medical Staff).

(3) Except as set forth below, the Supervising/Collaborating Physician shall be notified of a concern related to clinical competence, performance, and/or professional conduct that involves any Advanced Practice Professional or Allied Health Professional with whom the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the Supervising/Collaborating Physician will be copied on all correspondence that an Advanced Practice Professional or Allied Health Professional receives from the Medical Staff Leaders and/or may be invited to participate in any meetings or interventions. The Supervising/Collaborating Physician shall maintain all such information in a confidential manner. Notification to the Supervising/Collaborating Physician as described in this Section is not required, or may be delayed, if the Medical Staff

Leaders conducting the review determine that notification would be inconsistent with a fair and effective review.

13.D. QUESTIONS REGARDING AUTHORITY OF AN ADVANCED PRACTICE PROFESSIONAL OR ALLIED HEALTH PROFESSIONAL

(1) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an Advanced Practice Professional or Allied Health Professional, either to act or to issue instructions outside the physical presence of the Supervising/Collaborating Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Advanced Practice Professional's or Allied Health Professional's Supervising/Collaborating Physician validate, either at the time or later, the instructions of the Advanced Practice Professional or Allied Health Professional. Any act or instruction of the Advanced Practice Professional or Allied Health Professional shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Advanced Practice Professional's or Allied Health Professional's activities as permitted by the Board.

(2) Any question regarding the clinical practice or professional conduct of an Advanced Practice Professional or Allied Health Professional shall be immediately reported to the Medical Staff President, the relevant Department Chair, or the CMO who shall address the matter in accordance with Article 11 of these Bylaws. The individual to whom the concern has been reported may also discuss the matter with the Supervising/Collaborating Physician.

13.E. RESPONSIBILITIES OF SUPERVISING/COLLABORATING PHYSICIAN

(1) Physicians who wish to utilize the services of an Advanced Practice Professional or Allied Health Professional in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with these Bylaws or with Human Resources policies and procedures before the Advanced Practice Professional or Allied Health Professional participates in any clinical or direct patient care of any kind in the Hospital.

(2) The Supervising/Collaborating Physician will remain responsible for all care provided by the Advanced Practice Professional or Allied Health Professional in the Hospital.

(3) Supervising/Collaborating Physicians who wish to utilize the services of an Advanced Practice Professional or Allied Health Professional in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 13.B above.

(4) The number of Advanced Practice Professionals or Allied Health Professionals acting under the Supervision of one Supervising/Collaborating Physician, as well as the care they may provide, will be consistent with any applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Physician will make all appropriate filings with the relevant state board regarding the Supervision and responsibilities of the Advanced Practice Professional or Allied Health Professional, to the extent that such filings are required, and shall provide a copy of the same to Medical Staff Services.

13.F. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS AND LICENSED INDEPENDENT PRACTITIONERS

13.F.1. General:

Advanced Practice Professionals and Licensed Independent Practitioners shall not be entitled to the hearing and appeals procedures set forth in Article 12 of these Bylaws. Rather, any and all procedural rights to which these Practitioners are entitled are set forth in this Article.

13.F.2. Grounds for Hearing and Notice of Rights:

(a) Advanced Practice Professionals and Licensed Independent Practitioners are entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of requested clinical privileges;

(2) revocation of clinical privileges;

(3) suspension of clinical privileges for more than 30 days (except for precautionary suspension); or

(4) a Restriction of clinical privileges for more than 30 days.

(b) If the Board makes any of the above determinations without an adverse recommendation by the MEC, an Advanced Practice Professional or Licensed Independent Practitioner would also be entitled to request a hearing. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(c) The individual will receive Special Notice of the recommendation. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(d) If the Advanced Practice Professional or Licensed Independent Practitioner wants to request a hearing, the request must be in writing, directed to the CEO, within 30 days after receipt of written notice of the adverse recommendation.

(e) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

(f) The individual shall have the right to receive copies of the documentation relied upon by the MEC; however, prior to receiving any confidential documents, the individual requesting the hearing must sign a confidentiality agreement under which the individual agrees that all documents and information shall be maintained as confidential and within the protected peer review process and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel has executed Business Associate agreements in connection with any patient information contained in any documents provided.

13.F.3. Hearing Committee:

(a) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the Medical Staff President, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Advanced Practice Professionals, Licensed Independent Practitioners, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Practitioner requesting the hearing, or any competitors of the affected individual.

(b) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the CEO, in conjunction with the Medical Staff President, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

13.F.4. Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(c) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Practitioner requesting the hearing will be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The Practitioner requesting the hearing and the MEC may be accompanied at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The Practitioner requesting the hearing will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(g) The Practitioner requesting the hearing and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

13.F.5. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the Practitioner who requested the hearing and to the MEC.

(b) Within ten days after notice of such recommendation, the Practitioner who requested the hearing and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with these Bylaws during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(d) The request for an appeal will be delivered to the CEO by Special Notice.

(e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

13.F.6. Appellate Review:

(a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. The Board may serve as the Appellate Review Committee or the Chair of the Board may appoint an Appellate Review Committee composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(c) The Practitioner and the MEC will each have the right to present a written statement on appeal.

(d) At the sole discretion of the Appellate Review Committee, the Practitioner and a representative of the MEC may also appear personally to discuss their position.

(e) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

(f) The Practitioner will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 14

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

14.A.1. General Principles:

(a) All those involved in credentialing, privileging, and professional practice evaluation activities (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an "Interested Member."

(d) No Medical Staff member, Advanced Practice Professional, or Licensed Independent Practitioner has a right to compel the disqualification of another Practitioner based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(e) The fact that any individual chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.

(f) **Appendix G** to these Bylaws is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix G** and expand upon the guidelines that are summarized in the chart.

14.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or CMO.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or CMO.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or CMO of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

14.A.3. Implementation of Conflict of Interest Guidelines in **Appendix G**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix G** of these Bylaws:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, Leadership Council member, MEC member);

- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and

- Paragraph (c) describes how to apply the guidelines in **Appendix G** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations that Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the professional practice evaluation of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a practitioner whose application or provision of care is under review should not participate in the review process regarding the practitioner. However, if the patient-physician relationship has terminated and the review process does not involve the health condition for which the practitioner sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix G**:

(1) Significant Financial Relationship (e.g., when the Interested Member and other practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) Direct Competitor (e.g., practitioners in the same specialty, but in different groups);

(3) Close Friendships;

(4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) Active Involvement in Certain Prior Interventions with the Individual under Review (e.g., where the Interested Member was involved in the development of a prior Voluntary Enhancement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or collegial intervention efforts (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer or CMO, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix G** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

An Interested Member may participate as an individual reviewer so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

(i) participation in the review of applications for initial and renewed appointment and clinical privileges (which is subsequently reviewed by the MEC); and

(ii) participation as a case reviewer in professional practice evaluation activities (which is subsequently reviewed by the Leadership Council, Investigating Committee, and/or MEC).

(2) Leadership Council Members

As a general rule, an Interested Member may fully participate as a member of the Leadership Council because this committee does not possess any disciplinary authority and does not make any final recommendation that could adversely affect the appointment or clinical privileges of a Practitioner, which is only within the authority of the MEC and Board.

However, the chair of this committee always has the discretion to recuse an Interested Member if he or she determines that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the practitioner under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the appointment or clinical privileges of a Practitioner. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix G**.

(4) Investigating Committees

Once a formal Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect appointment or clinical privileges of a Practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix G**.

ARTICLE 15

CONFIDENTIALITY AND PEER REVIEW PROTECTION

15.A. CONFIDENTIALITY

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

(1) when the disclosures are to another authorized Practitioner or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any Practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO or the Medical Staff President (or the Medical Staff President-Elect if the Medical Staff President is the person committing the claimed breach).

15.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to these Bylaws and related Medical Staff documents shall be performed by "peer review committees" in accordance with state law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all departments;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to Department Chairs, committee chairs and members, officers of the Medical Staff, the CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state law.

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

ARTICLE 16

LEGAL PROTECTIONS FOR PRACTITIONERS
PERFORMING MEDICAL STAFF FUNCTIONS

Practitioners have significant personal legal protections from various sources when they perform functions pursuant to these Bylaws, the Professional Practice Evaluation (PPE) Policies, and all other policies of the Medical Staff and Hospital, as long as they maintain confidentiality and act in accordance with these Bylaws and related policies. The sources of these legal protections include:

(a) As set forth in Section 7.C.2 of the Bylaws, all Practitioners agree, as a condition of applying for appointment, reappointment, and/or clinical privileges, to release from liability, extend immunity to, and not sue other Practitioners for any actions, recommendations, communications, and/or disclosures made or taken in the course of credentialing and peer review (PPE) activities.

(b) All applicants for appointment, reappointment, and clinical privileges sign an application form by which they release from liability and agree not to sue other Practitioners who participate in credentialing and peer review (PPE) activities.

(c) Protections are also available under both the Illinois peer review statute and the federal Health Care Quality Improvement Act ("HCQIA") for Practitioners who participate in credentialing and peer review (PPE) activities. These Bylaws and related policies have been structured to take full advantage of these legal protections.

(d) The Hospital will indemnify Practitioners who perform functions under these Bylaws and related policies for any claims made against the Practitioner that are not completely covered by an applicable insurance policy, in accordance with the Hospital's corporate bylaws.

ARTICLE 17

AMENDMENTS

17.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by at least ten members of the Voting Staff, by the Bylaws Committee, or by the MEC.

(2) In the discretion of the MEC, amendments to the Bylaws shall be presented to the Voting Staff in one of the following two ways:

(a) Amendments Subject to Vote at a Meeting: The MEC shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the Voting Staff must be present, and (ii) the amendment must receive a majority of the votes cast by the Voting Staff at the meeting.

(b) Amendments Subject to Vote via Written or Electronic Ballot: The MEC shall present proposed amendments to the Voting Staff by written or electronic ballot, to be returned by the date and in the manner indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the Voting Staff. Along with the proposed amendments, the MEC shall provide a written report on the amendments either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the Voting Staff, and (ii) the amendment must receive a majority of the votes cast.

(3) The MEC shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

(4) All amendments shall be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request for same submitted by the Medical Staff President.

(6) Neither the Medical Staff nor the Board shall unilaterally (without seeking the advice of the other party) amend these Bylaws.

17.B. OTHER MEDICAL STAFF DOCUMENTS

(1) General:

(a) In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. These additional documents are the PPE Policies and the Medical Staff Rules and Regulations and they will be amended in accordance with this Section 17.B of the Bylaws.

(b) Notice of all such amendments will be provided to the Voting Staff promptly after adoption. If any members of the Voting Staff have any questions or concerns regarding an amendment, they may submit written comments on the amendments to the MEC and the System Leadership Group (as described in Section 17.B.2) for their determination whether any additional revisions should be made to the document in question.

(c) In addition, formal amendments to these other documents may also be proposed by a petition signed by at least 20% of the members of the Voting Staff. Any such proposed amendments will be reviewed by the MEC and the System Leadership Group, which will report on the proposed amendments either favorably or unfavorably before they are forwarded to the Board for its final action.

(d) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rules and Regulations are inconsistent with these Bylaws, they are of no force or effect.

(2) Review by System Leadership Group:

(a) Any MEC that proposes to amend these other Medical Staff documents shall first submit the proposed amendments to a system leadership group comprised of the following: (a) the CMO of each Memorial Health Hospital (or the CEO if the hospital has no CMO); (b) the Medical Staff President of each Memorial Health Hospital; and (c) the Memorial Health General Counsel.

(b) The role of this system leadership group is to assess whether the amendment is appropriate and helpful for the initiating Memorial Health Hospital, but also whether it would be beneficial for other Memorial Health Hospitals and

foster the goals of sharing expertise within the system and promoting consistency.

(c) Following its assessment, the system leadership group will provide its report and recommendation to all relevant Memorial Health Hospitals.

(3) Amendments Relevant to Only One Memorial Health Hospital:

(a) After receiving a favorable recommendation from the system leadership group, the initiating MEC may approve the amendment by a majority vote and then forward it to the Hospital Board for review and adoption.

(b) However, if the system leadership group has any questions or concerns about the proposed amendment, it will convene a meeting with the MEC to discuss and resolve whether to proceed with the amendment. If the disagreement cannot be resolved, the proposed amendment will be forwarded to the Hospital Board for its review with the concerns of the system leadership group being noted.

(4) Amendments Relevant to More Than One Memorial Health Hospital:

(a) After receiving a favorable recommendation from the system leadership group, the MEC for each relevant Memorial Health Hospital may approve the amendment by a majority vote and then forward the amendment to its Board for review and adoption.

(b) If there is any disagreement among the MECs concerning the amendment, a joint meeting of the MECs (or their representatives) and representatives of the system leadership group shall be scheduled to discuss and resolve the disagreement. In the unlikely event that a consensus cannot be achieved at that meeting, the proposed amendment shall be forwarded to the Memorial Health Board for further discussion and review.

(5) Board Action:

No amendment shall be effective at any Memorial Health Hospital unless and until it has been approved by the Board for that Hospital.

17.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 20% of the Voting Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Voting Staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Medical Staff President of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 18

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: April 15, 2022

Approved by the Board of Directors: April 18, 2022

APPENDIX A

TRAINING AND CERTIFICATION REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS AND LICENSED INDEPENDENT PRACTITIONERS

The following categories of Practitioners are permitted to practice in the Hospital as Advanced Practice Professionals and Licensed Independent Practitioners. Applicants for these categories of Practitioners who are permitted to practice at the Hospital must demonstrate training and certification, as applicable and as follows:

- **Certified Registered Nurse Anesthetist (CRNA)** – must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Current certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA) or by a predecessor or successor agency is required for initial applicants (or be actively seeking initial certification and obtain the same on the first examination for which eligible) and reapplicants;

- **Certified Registered Nurse Practitioner (CRNP)** – must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program (acute care is preferred) accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body is required for initial applicants (or be actively seeking certification and obtain the same on the first examination for which he or she is eligible) and reapplicants; and

- **Physician Assistant (PA)** – must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants (or be actively seeking initial certification and obtain the same on the first examination for which eligible) and reapplicants.

APPENDIX B

Those individuals currently practicing as Advanced Practice Professionals at the Hospital are as follows:

Certified Registered Nurse Anesthetists

Certified Registered Nurse Practitioners

Medical Resident Physicians in Training

Physician Assistants

APPENDIX C

Those individuals currently practicing as Allied Health Professionals at the Hospital are as follows:

Chiropractors

Surgical Assistants

APPENDIX D

Those individuals currently practicing as Licensed Independent Practitioners at the Hospital are as follows:

None at this time.

APPENDIX E

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Ambulatory Care	Coverage	Locums	Honorary
Basic Requirements							
Number of hospital contacts/2-year	≥ 24	≥ 6 & < 24	NA	N	NA	NA	N
Rights							
Admit	Y	Y	N	N	P	Y	N
Exercise clinical privileges	Y	Y	Y	N*	P	Y	N
May attend meetings	Y	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	N	P	P	P
Hold office	Y	N	N	N	N	N	N
Responsibilities							
Emergency Call	Y	N	N	F/C	Y	N	NA
Serve on committees	Y	Y	Y	Y	Y	Y	Y
Meeting requirements	Y	N	N	N	N	N	N
Dues	Y	Y	Y	Y	Y	Y	N
Comply w/ guidelines	Y	Y	Y	N	Y	Y	N

Y = Yes
N = No
NA = Not Applicable
P = Partial (with respect to voting, only when appointed to a committee)
F/C = No Emergency Call responsibilities but may be directed referrals from the Emergency Department for follow-up care.
* = No clinical privileges unless outpatient privileges are requested and granted

APPENDIX F

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services, including moderate sedation) by any Practitioner who has been granted clinical privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- chief complaint;
- details of present illness;
- review of systems and physical examination, to include pertinent findings in those organ systems relevant to the presenting illness;
- relevant medical history, appropriate to the age of the patient;
- medications and allergies;
- assessments, including problem list; and
- plan of treatment.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges to complete histories and physicals.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the attending physician.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay Documentation Requirements

A Short Stay History and Physical Form, approved by the MEC, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

APPENDIX G

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation						
	Provide Information	Individual Reviewer Application/ Case	Committee Member			Hearing Panel	Board
			Leadership Council	MEC	Investigating Committee		
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	N	N	R
Significant financial relationship	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	R	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	R	N	N	R

Y – (Green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – (Yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Leadership Council has no disciplinary authority.

In addition, the Chair of the Leadership Council always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

N – (Red "N") means the Interested Member should not serve in the indicated role.

R – (Red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Section 14.A.3 of these Bylaws.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.