MEDICAL STAFF BYLAWS

JENNIE EDMUNDSON HOSPITAL
MEDICAL STAFF BYLAWS

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BYLAWS OF
THE MEDICAL STAFF OF

METHODIST JENNIE EDMUNDSON

PREAMBLE

WHEREAS, Methodist Jennie Edmundson is a nonprofit corporation organized under the laws of the State of Iowa with the purpose of providing patient care, education, and research; and

WHEREAS, the Board of Directors wishes to delegate to the Medical Staff certain duties and responsibilities for monitoring the quality of medical care in the Hospital and reporting thereon to the Board and further wishes to delegate the authority and responsibility to make recommendations to the Board concerning an applicant's appointment or reappointment to the Medical Staff of the Hospital and the clinical privileges such applicant shall enjoy in the Hospital; and

WHEREAS, the Medical Staff is an organizational unit of the Hospital, organized for the purposes and with the authority described in these Bylaws. The Medical Staff is not a separate legal entity or association and is not capable of suing or being sued in its own name. Members of the Medical Staff performing functions described under these Bylaws and in accordance with these Bylaws do so as representatives of the Hospital.

THEREFORE, to discharge these duties and responsibilities to the Hospital in an orderly fashion, the practitioners practicing in Methodist Jennie Edmundson shall function and act in accordance with the following Bylaws and procedures which have been approved by the Board. Hospital administration shall cooperate with and assist the appointees to the Medical Staff in the accomplishment of this responsibility to the Hospital.

DEFINITIONS

For the purpose of these Bylaws and the accompanying Rules and Regulations, the following terms shall have the following meanings:

a. **ADMITTING PRACTITIONER** means the practitioner who orders the patient's admission to the Hospital.

b. **ALLIED HEALTH PRACTITIONER (AHP)** means an individual who is permitted by law and by the Hospital to render certain health care services in the Hospital, but who is not eligible for independent clinical privileges. AHPs must be employees of the Hospital, under written contract to the Hospital for their services, or registered under a registration and approval system established in Board policies or Rules and Regulations.

c. **APPLICANT** means a practitioner who has made application for appointment or reappointment to membership on the Medical Staff or for clinical privileges, or both, and shall include individuals who have provisionally been appointed members or who provisionally hold privileges.

d. **ATTENDING PHYSICIAN** means the physician on the Active Staff who has primary responsibility for the patient's care until that responsibility is formally

relinquished even when the care is directly provided by the Admitting Practitioner in a co-admitting relationship.

e. **BOARD** means the Board of Directors of the Hospital which has the overall responsibility for the conduct of the affairs of the Hospital including those of the Medical Staff by virtue of the authority vested in it by law and charter and by its Bylaws.

f. **CHIEF OF STAFF** means the chief officer of the Medical Staff.

g. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted by the Board on recommendation of the Medical Staff to a practitioner to provide specified diagnostic and/or therapeutic health services independent of the direction or supervision of a physician or other practitioner. AHPs do not exercise privileges within the meaning of this definition.

h. **CREDENTIALING ENTITY** means the entity that collects data for credentialing purposes according to policies and procedures adopted by the Medical Staff and the Board. The credentialing entity may be the Medical Staff Coordinator or designee or a contracted organization.

i. **DAYS** mean actual calendar days, counting all weekend days and holidays, whenever time frames expressed in days are stated in these Bylaws, unless specific reference is made to other means of counting.

j. **COMMITTEE** means the Executive Committee of the Medical Staff unless it is specifically written "Executive Committee of the Board."

k. **LICENSED INDEPENDENT PRACTITIONER** means individual permitted by law and the Hospital to provide care and services without direction or supervision, within the scope of the individual's license, and consistent with individually granted clinical privileges.

l. **MEDICAL STAFF** means the individual practitioners who are given privileges to treat patients at Methodist Jennie Edmundson and who are collectively organized into the Medical Staff for purposes of accepting and discharging delegated responsibility.

m. **MEMBER** means a practitioner who is appointed by the Board to membership on the Medical Staff and who, therefore, enjoys the prerogatives established for members and is subject to the rules and accountability imposed upon members by these Bylaws and the Bylaws of the Hospital.

n. **PEER REVIEW** means the process of evaluating care rendered generally or to individual patients in the Hospital and the process of evaluating the credentials, fitness or performance of individual practitioners. Peer review includes all functions treated as peer review under Iowa law and all functions treated as professional review activity or otherwise eligible for immunity under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq*. Therefore, peer review includes, without limitation, risk management activities of the Medical Staff, professional review actions involving practitioners, the credentialing, application, appointment and reappointment process, the hearing and appeals

process, the utilization review and quality assurance functions carried on within the Medical Staff committee or Hospital structure. Refer to Peer Review Policy.

o. **PEER REVIEW COMMITTEE** means the committees, subcommittees including *ad* hoc committees, departments, officers and individuals charged under these Bylaws or by the appointing authority with peer review responsibility. Each Medical Staff committee, department, and officer is hereby expressly constituted a peer review committee for purposes of engaging in peer review activity within his, or its, area of primary or delegated responsibility. This appointment applies to standing and special committees and to individuals carrying out the work of units, such as departments or committees, of the Medical Staff.

p. **REVIEW RECORDS** means all records, reports, and information gathered or created by peer review committees in the discharge of peer review activities.

q. **PRACTITIONER** means an individual licensed and authorized by the state and permitted by the Hospital to practice independently in the Hospital and to apply for, hold, and exercise clinical privileges.

r. **PRESIDENT** means the Chief Executive Officer of the Hospital or his designee.

s. **TIME PERIODS** means all time periods referred to in these Bylaws for action by officers, committees, or panels of the Medical Staff or the Board and references to meetings at which action is to be taken by them. Such references are advisory only and are not mandatory. While no such actions shall be required to be accomplished in less time than that specified, extensions should be granted or permitted for reasonable cause or for the convenience of participants provided that the fundamental fairness of the process is not undermined by so doing.

Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.

ARTICLE I
PURPOSE

The purposes of the Medical Staff of Methodist Jennie Edmundson, acting through its duly appointed and functioning clinical departments and committees and in accordance with these Bylaws shall be:

1. To discharge those duties and responsibilities delegated to it by the Board to monitor the quality of medical care in the hospital and to make recommendations thereon to the Board so that all patients admitted to or treated at any of these facilities, departments, or services of the Hospital receive quality care.

2. To make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff; to recommend to the Board the clinical privileges such applicant or member shall have in the hospital; to review and evaluate on a continuing basis such clinical privileges as have been given; and to recommend to the Board any appropriate action that may be necessary in connection with any appointee to the Medical Staff, to the end that there shall be an appropriate level of professional performance by all persons authorized to practice in the Hospital.

3. To establish procedures whereby issues concerning the Medical Staff and the Hospital administration or Board may be discussed both within the Medical Staff and with the Board and the administration.

4. To establish specific rules and regulations to govern actions and professional responsibilities of appointees to the Medical Staff.

5. To provide an appropriate educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized from time to time by the Board.

6. To make all reasonable efforts to assure the same level of quality of patient care by all individuals granted a specific clinical privilege.

7. To cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and postgraduate education.

8. To develop Medical Staff leaders through educational opportunities.

ARTICLE II
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff:

PART A: PROVISIONAL STAFF

All practitioners shall indicate on their application which category of staff to which they are applying. If provisionally appointed under Article VI, Part C, all such practitioners shall first be appointed to the Provisional Staff while it is determined through the process set forth in Article VI, Part G, Section 1 of these Bylaws whether the practitioner qualifies for the category of staff and for the requested privileges applied for. Except as expressly limited, the practitioner must meet all of the qualifications of the category of staff for which he is applying, including, as applicable, service on committees, attendance at meetings, emergency service care and reasonable call coverage responsibilities, on a shared basis with members of the Active Staff, Courtesy Staff, and Provisional Staff as applicable, consultation, teaching assignments, and minimum patient contact requirements. Practitioners appointed to the Provisional Staff may not vote, hold office, serve on Medical Staff committees, nor serve as chairmen of such committees unless they have been on Provisional Staff for one year and have been approved by the Executive Committee according to criteria set forth in Medical Staff policies.

Section 1. Duration. Appointment to the Provisional Staff shall be for twenty-four (24) months, provided, however, that upon recommendation of the Department and approval of the Executive Committee, a Provisional Staff member may be deemed to have completed the objectives for Provisional Staff membership after eighteen (18) months.

Section 2. Minimum Patient Contact Requirements. In order to permit observation and evaluation of clinical competency, members of the Provisional Staff shall, as applicable to the practitioner's specialty, perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact with Methodist Jennie Edmundson Hospital (MJEH), a Nebraska Methodist Health System (NMHS) facility or any other facility from which the MJEH Medical Staff can obtain reliable information to assess current competence.

Section 3. Final Determination. At the end of the Provisional period, based on observation and performance during the Provisional period, the practitioner will be assigned to his requested category of staff, assigned to a different category of staff, or denied membership and privileges. If membership and privileges are denied at the end of this period, all rights under Article VIII (Hearing and Appeal Procedures) shall be deemed waived and shall not apply. A practitioner may not remain on Provisional Staff beyond the end of the provisional period.

PART B: ACTIVE STAFF

The Active Staff shall consist of those physicians and oral surgeons who are located within the geographic service area of the Hospital, who regularly admit, co-admit or attend patients at the Hospital, and who discharge all the responsibilities of appointment to the Active Staff, including, where appropriate, service on committees and in departments, service to patients, emergency service care and reasonable call coverage responsibilities on a shared basis with members of the Active Staff, Provisional Staff, and Courtesy Staff, as applicable, consultation, and teaching assignments. Members of the Active Staff must have first served some other category of staff or not less than 18 months on the Provisional Staff. All members of the Active Staff shall perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact with MJEH, another NMHS facility, or any other facility from which the MJEH Medical Staff can obtain reliable information to assess current competence. All applicants for Active Staff shall agree to participate actively in the implementation of the Utilization Management Program. Practitioners appointed to the Active Staff shall be entitled to vote, to hold office, to serve on Medical Staff committees, and serve as chairmen of such committees and of departments to which they are assigned.

The Active Staff is the highest organizational unit of the Medical Staff and is primarily responsible for achieving the purposes of the Medical Staff and discharging all delegated responsibility from the Board.

PART C: COURTESY STAFF

The Courtesy Staff shall consist of practitioners who do not seek or do not qualify for Active Staff status. Members of the Courtesy Staff are practitioners who have been granted clinical privileges to admit or co-admit and attend inpatients and outpatients at MJEH. In general, members of the Courtesy Staff shall demonstrate responsible participation in Medical Staff meetings to which they are invited or committees to which they are assigned; shall pay dues, and shall discharge such additional responsibilities as are established from time to time. When necessary due to the number of physicians in a specialty, members of the Courtesy Staff may be obligated to provide a reasonable amount of call coverage on a shared basis with members of the Active Staff and Provisional Staff, as applicable. Members of the Courtesy Staff shall not be eligible to vote (except as members of committees to which they are assigned as voting members), to hold office, or to serve as Department Chair, Section Chair, or as a member of the Executive Committee unless approved by the Executive Committee according to criteria set forth in Medical Staff policies. All members of the Courtesy Staff shall perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact with MJEH, a NMHS facility or the physician's primary location to permit the Medical Staff to assess current competence.

PART D: ASSOCIATE STAFF

The Associate Staff shall consist of non-physician practitioners who qualify for clinical privileges and who are located within the primary service area of the Hospital. Practitioners appointed to

the Associate Staff may not vote, hold office, serve on Medical Staff committees, nor serve as chairmen of such committees unless approved by the Executive Committee according to criteria set forth in Medical Staff policy.

PART E: *EMERITUS* STAFF

The *Emeritus* Staff shall consist of practitioners who are not clinically active in the Hospital but who have previously practiced actively at the Hospital for ten (10) years or longer. These will usually be practitioners who have retired from active hospital practice. Persons appointed to the *Emeritus* Staff shall not be eligible to attend patients, to vote, to hold office, or to serve on standing medical staff committees but may be appointed as counsel to committees. They may, but are not required to, attend Medical staff meetings.

PART F: AMBULATORY STAFF

The Ambulatory Staff consists of members who do not seek, or do not qualify for clinical privileges to treat inpatients. The Ambulatory Staff may include members who provide services at MHS-affiliated outpatient facilities and clinics. The primary purpose of the Ambulatory Staff category is to enable these members' patients access to MJE services by referral to members of the Active or Courtesy Staff, while allowing these members to provide follow-up care on an outpatient basis and providing additional physician alternatives for patients with outpatient needs. Members of the Ambulatory Staff may not admit inpatients but may initiate an admission by referring a patient to a physician with admitting privileges. Ambulatory Staff members may visit their hospitalized patients, review their patients' medical records and document information (but not orders) in their patients' inpatient records. Ambulatory Staff members may not exercise any inpatient clinical privileges or outpatient surgical privileges, but may be engaged in non-surgical ambulatory care of outpatients in MJE's outpatient and diagnostic facilities. Members of the Ambulatory Staff shall demonstrate responsible participation in Medical Staff meetings to which they are invited or committees to which they are assigned; shall pay dues if required and shall discharge such additional responsibilities as are established from time to time. Members of the Ambulatory Staff may vote at meetings of the Medical Staff and Department meetings, and they may serve as voting members of committees to which they are assigned. Ambulatory Staff members are not subject to Focused Professional Practice Evaluation upon initial appointment, nor are they subject to Ongoing Professional Practice Evaluation. Practitioners appointed to the Ambulatory Staff may not vote, hold office, serve on Medical Staff committees, nor serve as chairmen of such committees unless approved by the Executive Committee according to criteria set forth in Medical Staff policies.

PART G: MEDICAL STAFF CATEGORIES – GENERAL

Members of the Courtesy and Associate Staffs may be appointed to standing or special committees of the Medical Staff and, when so appointed, shall be entitled to vote on matters coming before such committees unless such authority is specifically withheld by the appointing authority, and further shall be subject to the attendance requirements adopted for such committees, from time to time, by the Executive Committee. Members of the Courtesy and Associate Staffs are encouraged to attend the scientific portion of Medical Staff and department meetings.

PART H: REFERENCE PRACTITIONERS

Certain practitioners who do not hold privileges at the Hospital may be granted permission to refer their patients to the Hospital for outpatient diagnostic tests and therapies to be performed by Hospital personnel and reported back to the practitioner, with or without professional

interpretation. Reference practitioners must be licensed to order the diagnostic test referred. The Hospital may, in its sole discretion, refuse to perform a test or therapy ordered by a reference practitioner.

PART I: ALLIED HEALTH PRACTITIONERS

Section 1. Categories. Allied Health Practitioners or AHPs are individuals who provide patient care services at the Hospital, but only as dependent practitioners under the supervision of or collaboration with other privileged practitioners. AHPs may participate in patient care at the Hospital only if:

(a) They are employees of the Hospital, in which case they will be subject to the job description, the personnel and administrative guidelines of the Hospital, and assigned supervision, the same as any other employee of the Hospital; or

(b) They are under contract to the Hospital to provide specified services, in which case they will be subject to the terms of the contract; or

(c) They are registered to provide services at the Hospital, in which case they will be subject to this policy, the guidelines of the Credentials Committee, and the terms of such registration.

Section 2. Qualifications. Qualifications for employed, contracted or registered AHPs will be developed by the Hospital and, with the assistance of the Medical Staff, through the Credentials Committee.

Section 3. Registration. Application for registration of an AHP, on a form provided by the Hospital, shall be submitted to the President who shall submit it through the prescribed Medical Staff channels for review and recommendation back through the Credentials Committee, Executive Committee and Administration. Each applicant must meet all requirements of the state of Iowa for the applicable licensure, registration, and/or certification and must agree to abide by all of the Bylaws and Rules and Regulations of the Medical Staff and Hospital. Registration shall be granted for two (2) years and shall be in effect only during such time as the registrant continues to be employed by or affiliated with the supervising practitioner who must be a credentialed practitioner on the MJE medical staff, as such is a requirement for the AHP's category. Registration may be terminated by the President at any time. Termination of registration shall not entitle the supervising or collaborating physician or the registrant to the use of the provisions of Articles VI, VII, and VIII of these Bylaws or of Article IX of the Corporate Bylaws.

It shall be the responsibility of the practitioner employing or sponsoring the AHP to ensure that professional liability insurance covering the AHP for any activities in the Hospital in coverage and amount equivalent to that required for members of the Medical Staff is in effect and to have to furnish evidence of such furnished to the Hospital. If required under state law, all AHPs must designate an alternate supervising or collaborating practitioner.

The supervising or collaborating physician and the AHP jointly provide care and services to the patient, but the supervising or collaborating physician remains fully responsible for the quality of care and medical management of the patient.

Section 4. Removal and Fair Hearing Procedures. The Hospital retains the right, through the President, to suspend or terminate any or all of an AHP's practice authority or functions with or without the Executive Committee's or Credentials Committee's recommendation.

An AHP whose practice authority is suspended, limited or revoked shall be told the reasons for such action and, if he requests, shall be entitled to have such action reviewed by the Credentials Committee. At any such review, the individual and his supervising physician may be present and shall be allowed to fully participate.

If the AHP wishes to appeal the outcome of a review by the Credentials Committee, such practitioner (along with his supervising or collaborating physician, if requested) may seek review of the Credentials Committee's decision by the President. The decision of the President in such matters shall be final.

ARTICLE III
ORGANIZATION OF THE MEDICAL STAFF

PART A: GENERAL

Section 1. Medical Staff Year. For the purpose of these Bylaws, the Medical Staff Year commences on the 1st day of February and ends on the 31st day of January of each year.

Section **2. Dues**. All persons appointed to the Medical Staff shall pay annual staff dues as established by the Medical Staff.

PART B: OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and Secretary-Treasurer. Officers must be members of the Active Staff at the time of nomination and election and must continue as such during their term of office unless approved by the Executive Committee according to criteria set forth in Medical Staff policies. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 1. Chief of Staff. The Chief of Staff or his designee shall:

(a) Act as the chief medical officer of the Hospital, in coordination and cooperation with the President in matters of mutual concern involving the Hospital;

(b) Act as Chairman of the Executive Committee;

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

(d) With the concurrence of the Executive Committee, appoint committee chairmen and members to all standing and special Medical Staff committees except the Executive Committee, other than the at-large Executive Committee members who are appointed by the Chief of Staff, or except where otherwise specified herein;

(e) Serve as an *ex-officio* member of all Medical Staff committees to which he is not already a named member. He shall serve on the Joint Conference Committee and as an *ex-officio* member of the Directors without vote;

(f) Represent the views, policies, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Board and to the President;

(g) Provide ongoing liaison on medical matters with the President and the Board:

(h) Convey and explain the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to assess medical care;

(i) Be the spokesman for the Medical Staff in its external professional and public relations; and

(j) Be responsible for meeting the Medical Staff requirements for accreditation by working with the department chairmen. He shall report the accreditation status to the Executive Committee, the Medical Staff, and the Board.

Section 2. Vice Chief of Staff. The Vice Chief of Staff shall:

(a) Assume all the duties and have the authority of the Chief of Staff in the event of the Chief of Staff's temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason.

(b) Be a member of the Executive Committee of the Medical Staff; serve on the Joint Conference Committee and as an *ex-officio* member of the Board of Directors without vote; automatically succeed the Chief of Staff when the latter fails to serve for any reason; and

(c) Perform such duties as are assigned to him by the Chief of Staff.

(d) Chair the Credentials and Peer Review Committees

When the office of the Chief of Staff is vacated prematurely, the Vice Chief of Staff shall assume the office for the remainder of the Medical Staff Year.

If the Vice Chief of Staff is unable to succeed to this office, the procedure as outlined in Section 4 shall be followed. Vacancies in the offices of Vice Chief of Staff and Secretary-Treasurer shall be filled in like manner.

Section 3. Secretary-Treasurer. The Secretary-Treasurer shall:

(a) Ensure that accurate and complete minutes of all staff and Executive Committee meetings are kept;

(b) Collect and be custodian of staff dues and funds and make disbursements authorized by the Executive Committee or its designees; and

(c) Call meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as pertain to his office. Where there are funds to be accounted for, he shall make the accounting.

Section 4. Election and Removal.

(a) Officers shall be elected at the annual meeting of the Medical Staff to a two-year term of office. The Nominating Committee shall nominate one (1) candidate for each vacant position and report to the Executive Committee no later than its last meeting held previous to the meeting at which the election will be held. The Nominating Committee's report shall also be published for the information of the members of the Active Staff.

(b) The nominations proposed by the Nominating Committee shall be presented by the chairman of that Committee at the appropriate meeting and nominations shall be accepted from the floor or via a written petition provided in advance to the Nominating Committee with at least thirty-five (35) signatures of members of the Active Staff. Officers shall be elected by majority vote of those members of the Active Staff who are present at the meeting at the time the vote is taken. If two or more nominations have been made for the same office, the vote shall be by written secret ballot. Each officer shall serve until his successor has been elected. The elected officers will require the approval of the MJEH Board of Directors.

(c) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

(d) The Executive Committee may, by a two-thirds (2/3) majority vote of the entire elected committee, remove any Medical Staff officer for conduct detrimental to the interests of the Hospital or if he is suffering from a physical or mental infirmity that renders him incapable of fulfilling the duties of his office, providing notice of the meeting at which such action takes place shall have been given in writing to such officer at least ten (10) days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his own behalf prior to the taking of any vote on his removal.

PART C: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Staff Meeting. The Active Staff shall, at least ten (10) days before the end of the Medical Staff year, hold a meeting at which officers for the ensuing year shall be elected. At that time, additional nominations may be received from the floor.

All appointees to the staff are entitled and encouraged to attend the meetings of departments to which they are assigned and the scientific portion of annual, and special Medical Staff meetings.

Section 2. Regular Staff Meetings. The Medical Staff shall meet at least annually and may meet more frequently, as needed, upon the call of the Chief of Staff or the Executive Committee, for the purpose of reviewing and evaluating departmental and committee reports and recommendations and to act on any other matters placed on the agenda by the Chief of Staff.

Section 3. Special Staff Meetings. Special meetings of the Medical Staff may be called at any time by the Board, the President, the Chief of Staff, a majority of the Executive Committee of the Medical Staff, or a petition signed by not less than one-fourth (1/4) of the Active Staff. In the event that it is necessary for the staff to act on a question without being able to meet, the Active Staff may be presented with the question by written communication (i.e. mail or email)

and their votes returned to the Chief of Staff by written communication. Such a vote shall be binding so long as a majority of the staff eligible to vote consents in writing to the action taken.

Section 4. Notice of Special Meeting. A written notice stating the place, day, hour, and purpose of any special meeting of the Medical Staff shall be mailed to each member eligible to vote or posted in the Hospital as required by these Bylaws, not less than seven (7) days before the date of such meeting. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to each member at his address as it appears on the records of the Hospital, when emailed to the member at his email address as it appears on the records of the Hospital, or when posted in the Hospital. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

Section 5. Quorum. The presence of twenty-five percent (25%) of the members eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. A quorum is presumed unless challenged in writing to the Executive Committee before the next Executive Committee meeting.

Section 6. Agenda. The agenda at any Medical Staff meeting shall be at the discretion of the Chief of Staff.

All important actions of the Executive Committee shall be included in the Executive Committee's report to the Medical Staff at any regular or special meeting called for this purpose. The Active Staff, by proper motion and majority vote, may require reconsideration of any such action by the Executive Committee at its next meeting. Such reconsideration could result in the change or withdrawal of any such action that has not been approved by the Board or carried into effect.

PART D: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings. Members of each department shall meet as a department at least annually at a time set by the chairman of the department to review and evaluate the clinical work of the department and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairman.

Section 2. Committee Meetings. All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairman of the committee. The agenda for the meeting and its general conduct shall be set by the chairman.

Section 3. Special Department and Committee Meetings.

(a) A special meeting of any committee or department may be called by or at the request of the chairman, by the Chief of Staff, or by a petition signed by not less than one-fourth (1/4) of the members, but not less than two (2) members, of the department or committee. Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting shall be given to each member of the committee or department not less than seven (7) days before the time of such meeting or posted in the Hospital as required by these Bylaws. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member's address as it appears on the records of the Hospital. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

(b) In the event that it is necessary for a committee or department to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the chairman of the committee or department. Such a vote shall be binding so long as a majority of the committee or department members eligible to vote consents in writing to the action taken.

Section 4. Quorum. The presence of at least twenty-five percent (25%) of persons eligible to vote shall constitute a quorum for all actions. A quorum is presumed unless challenged in writing to the Executive Committee before the next Executive Committee meeting. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding, even though less than a quorum exists at a later time in the meeting.

Section 5. Minutes. Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the votes taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Executive Committee and at the same time to the President unless otherwise specified for certain committees in Article V and in Appendix A hereto. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

PART E: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Posting Notice of Meetings. Notice of all meetings of the Medical Staff and of departments and committees shall be posted in a conspicuous place in the Medical Staff Lounge one week in advance of such meetings. For all meetings, except special meetings of the Active Staff, such posting shall be deemed to constitute actual notice to the persons concerned if it occurs seven (7) days prior to the meeting.

Section 2. Attendance Requirements. Each appointee to the Medical Staff shall be required to attend at least fifty percent (50%) of the meetings of the committee of which he is a member in each Medical Staff year, but is expected to attend all meetings. Any person who is compelled to be absent from any meeting, but who desires to receive credit for attendance at that meeting, shall promptly communicate to the chairperson of the appropriate department, committee or Medical Staff Coordinator in Administration the reason for such absence. Credit shall then be at the discretion of the appropriate chairperson. The failure of any member to meet the foregoing attendance requirements may constitute grounds for removal from a committee and may be reported to the Credentials Committee for consideration as part of reappointment.

Section 3. Rules of Order. Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings.

Section 4. Voting. Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

ARTICLE IV
ORGANIZATION OF CLINICAL DEPARTMENTS

PART A: CLINICAL DEPARTMENTS

Section 1. Assignment to Departments. All practitioners awarded clinical privileges will be assigned by the Board to one of the clinical departments of the Medical Staff where they will function under the general supervision and authority of the chairman of the department and

such departmental rules as may be adopted. Assignment to one department does not preclude holding privileges in other departments.

Section 2. List of Departments. The following clinical departments are authorized. Additional departments may be established and existing departments may be consolidated by the Board after considering recommendations from the Executive Committee of the Medical Staff.

(a) Primary Care Services Department

(b) Surgical Services Department

Departments must have a minimum of three (3) members. If any department membership becomes less than three (3) and remains at that level for three (3) consecutive months, the Executive Committee shall assign the remaining members to another appropriate department or reconstitute the former department into a division of the other department to which the members are assigned.

Section 3. Divisions. Divisions are units of clinical departments grouped around common specialties or subspecialties. Divisions may assist the departmental chairman with matters within their specialty or subspecialty, but are subject to general departmental supervision, quality assessment, and other peer review authority. The Divisions of the Primary Care Services Department are: Internal Medicine, Family Practice, Pulmonology, Infectious Disease, Cardiology, Psychiatry, Emergency Services, Pediatrics, Pathology, Radiology and such other Divisions as the departmental chairman shall designate. The Divisions of the Surgical Services Department are: Surgery, Anesthesiology, Gastroenterology, Obstetrics and Gynecology and such other Divisions as the departmental chairman shall designate. Divisions may meet at any time to discuss issues pertinent to the division in order to make recommendations to the relevant Department and/or Department Chairman.

Section 4. Functions of Departments.

(a) Establish criteria for granting of clinical privileges in the department and through the department chairman, make recommendations for appointment and reappointment based upon such criteria to the Credentials Committee and the Executive Committee.

(b) Each department shall meet at least annually and report to the Executive Committee.

(c) Each department shall cooperate with the Comprehensive Review Committee in the analysis of the clinical work of the department.

(d) Each department shall conduct performance improvement activities that relate to department services, including exercising responsibility and oversight over national quality indicators relating to primary care services, if requested.

(e) Each department shall review Mortality/Morbidity findings for divisions within the department, if requested.

Section 5. Department Chairmen.

(a) The chairman of each department shall be a member of the Active Staff who is Board Certified or eligible for Board Certification by an appropriate National specialty board.

(b) The Nominating Committee shall nominate a department chairman and such other officers as may be desired by the department. The chairman of the Nominating Committee or designee shall present the nominations at the last Department meeting of the year. Nominations may be made from the floor or via written petition provided in advance to the Nominating Committee with at least twenty (20) signatures of department members.

(c) The chairman of each department and such other officers as may be desired by the department shall be elected by the department by a majority of the department members present and voting at the department meeting or by a majority of the department members who have returned voting ballots. If two or more nominations have been made for the same office, the vote shall be by written secret ballot. If there are three (3) or more candidates for the same office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate. The chairman and each other officer elected shall serve a two-year term and shall be eligible to succeed himself in office.

(d) A chairman, during his term of office, may be removed by a two-thirds (2/3) vote of all Active Staff members of the department.

Section 6. Functions of Department Chairmen. Each chairman shall:

(a) Be responsible for the organization of all Medical Staff activities of the department and integration into the Hospital and coordination with other departments.

(b) Be a member of the Executive Committee.

(c) Review the professional performance of all applicants and practitioners with clinical privileges in the department and report and recommend thereon to the Credentials Committee as part of the appointment or reappointment process and at such other times as may be indicated. This process includes the implementation of a monitoring process for focused professional evaluation of Provisional appointees that ensures proof of current competence in the clinical privileges applied for.

(d) Be responsible for enforcement within the department of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations.

(e) Be responsible for implementation within the department of actions taken by the Board and the Executive Committee of the Medical Staff.

(f) Recommend to the Medical Staff the criteria for clinical privileges in the department and recommend the appropriate numbers of qualified and competent persons to provide care, treatment and services.

(g) Be responsible for the establishment, implementation, and effectiveness of the teaching, education, and research program in the department.

(h) Oversee the professional performance of all practitioners assigned to the department including orientation and continuing education of all persons in the department.

(i) Assure that the quality and appropriateness of patient care, treatment and services provided within the department are continuously monitored, evaluated and improved. This responsibility includes, but is not limited to overseeing the processes related to focused and ongoing professional practice evaluations and related proctoring and other mechanisms and tools employed to evaluate the competence of practitioners in the department.

(j) Establish additional divisions within the department subject to the approval of the Executive Committee and appoint chiefs thereof.

(k) Be responsible for clinically related activities of the department.

(l) Be responsible for administratively related activities of the department.

(m) Assess and recommend to the Executive Committee off-site sources for needed patient care, treatment and services not provided by the department or the hospital and recommend space and/or other resources needed by the department.

(n) Determine qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

(o) Develop policies and procedures that guide and support the provision of care, treatment and services in the department and make certain that such policies and procedures are kept current.

(p) Coordinate and integrate the department into the primary functions of the Hospital and interdepartmental and intradepartmental services.

ARTICLE V
COMMITTEES OF THE MEDICAL STAFF

PART A: APPOINTMENT

Section 1. Chairmen.

(a) Appointment of all committee chairmen, unless otherwise provided for in these Bylaws, will be made by the Chief of Staff with the concurrence of the Executive Committee. All chairmen shall be selected from among persons appointed to the Active Staff.

(b) Such recommended appointments will be presented by the Chief of Staff to the Executive Committee by its first meeting after the end of the Medical Staff Year, for a term of two (2) years.

(c) The chairman of any committee may be removed during his term of office by the Chief of Staff with concurrence of the Executive Committee.

Section 2. Members.

(a) Medical Staff members of each committee, except as otherwise provided for in these Bylaws, shall be appointed for a term of two years by the Chief of Staff with the concurrence of the Executive Committee, by at least the next Executive Committee meeting, with no limitation in the number of terms they may serve. All members appointed by the Chief of Staff may be removed and vacancies filled by him with concurrence of the Executive Committee. All Hospital members of each committee, except as otherwise provided for in these Bylaws, shall be appointed by the Hospital's President with no limitation in the number of terms they may serve. All members appointed by the President may be removed and vacancies filled by him.

(b) With the exception of all committees to which they may be directly named or appointed by the Nominating Committee, the President or his designee(s) and the Chief of Staff or his designee shall be members, *ex-officio* without vote, on all committees.

Section 3. Powers and Responsibilities. Each committee shall have the responsibilities assigned to it in these Bylaws or by the Chief of Staff, the Executive Committee, or other appointing authority, together with the powers and authority expressed or reasonably necessary for the discharge of its responsibilities. A committee may, upon notice to a practitioner, compel such practitioner to attend a meeting to discuss such practitioner's practice, performance, cases, or qualifications.

PART B: EXECUTIVE COMMITTEE

Section 1. Composition.

The Executive Committee shall consist of:

(a) the officers of the Medical Staff;

(b) the chairman of each department;

(c) one (1) additional member from the Primary Care Services Department, elected by such Department;

(d) (d) one (1) additional member from the Surgical Services Department, elected by such Department;

(e) the chairman of the Comprehensive Review Committee;

(f) Two (2) members of the medical staff appointed by the Chief of Staff;

(g) The medical directors or designee of:

Anesthesiology

Pathology

Radiology

Emergency Services

Hospital Medicine

The Chief of Staff shall serve as chairman of the Executive Committee.

(g) Any department of the Medical Staff may, by a two-thirds (2/3) vote of the Active Staff membership of the department, recall their representative(s) to the Executive Committee for conduct detrimental to the interests of the Hospital or if he is suffering from a physical or mental infirmity that renders him incapable of fulfilling the duties of his office. The vacancy thus created shall be filled, for the period of the unexpired term, in the same manner as specified for the original selection of the chairman or the representative(s) recalled.

Section 2. Election and Removal.

(a) The additional members of the Executive Committee from the departments shall be elected by the department members at the annual meeting of each department. Each member of the department shall have the same number of votes as the number of positions available within the department for Executive Committee members. Multiple votes may not be cast for the same nominee by a single voting member. A voting member is not required to use all his votes. The nominees receiving the most votes respectively will fill each open position on the Executive Committee for the department until all such open positions are filled. Each member elected to the Executive Committee will serve for a two-year term of office. Any such member may be reelected for additional two-year terms.

(b) Nominations shall be accepted from the floor at the department meeting designated for the acceptance of nominations or via a written petition provided in advance to the department chairman by a nominee with at least ten (10) signatures of fellow department members. For elections held at a department meeting the Executive Committee members shall be elected by those members of the Department who are members of the Active Staff and who are present at the meeting at the time the vote is taken, with the nominees receiving the most votes respectively filling each open position on the Executive Committee for the department until all such open positions are filled, as described in the foregoing Section 2(a) above. Each member of the Executive Committee shall serve until his successor has been elected.

Section 3. Duties. The duties of the Executive Committee shall be:

(a) To represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws. However, at any meeting of the Medical Staff, any action of the Executive Committee occurring in the interim

since the last meeting of the Medical Staff may, by simple majority vote of the Active Staff, be rescinded or remanded to the Executive Committee for reconsideration.

(b) To coordinate the activities and general policies of the various departments and make recommendations regarding the Medical Staff's structure.

(c) To receive and act upon department and committee reports and to make recommendations concerning them to the President and the Board.

(d) To implement policies of the Medical Staff which are not the responsibility of the departments.

(e) To provide liaison among Medical Staff, the President, and the Board.

(f) To recommend action to the President on matters of a medico-administrative and Hospital Administrative nature.

(g) To ensure that the Medical Staff is kept abreast of the Joint Commission on Accreditation of Healthcare Organizations' accreditation program and informed of the accreditation status of the Hospital.

(h) To take steps to ensure the enforcement of Hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff and to make recommendations to the Board on actions described in Article VII.

(i) To review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and, as a result of such review, to make recommendations for reappointments and renewal of or changes in clinical privileges, and to recommend termination of Medical Staff membership and clinical privileges.

(j) To be responsible to the Board for the general quality of medical care rendered to patients in the Hospital, and to formulate policies leading to improvements in the quality of medical care and the maintenance of appropriate standards for patient care.

(k) To review the credentials of all applicants and to make recommendations for appointment to the Medical Staff, assignments to departments, and delineation of clinical privileges.

(l) To request evaluations of practitioners privileged through the Medical Staff process when there is doubt about an applicant's ability to perform the privileges requested.

The chairman of the Executive Committee, his representative, and such members of his committee as he deems necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make, it being the purpose of these Bylaws to increase direct communication between the Board and the Executive Committee on all matters within the scope of the Executive Committee's duties.

Section 4. Meetings, Reports, and Recommendations. The Executive Committee shall meet preferably on a monthly basis, but not less frequently than quarterly to transact pending business. The Secretary shall ensure reports of all meetings are maintained, which reports shall include the minutes of the various committees and departments of the staff. Copies of all minutes and reports of the Executive Committee shall be transmitted to the President routinely as prepared, and actions of the Executive Committee shall be reported to the staff as a part of the Executive Committee's report at each staff meeting. Recommendations of the Executive Committee shall be transmitted through the Chief of Staff to the Board of Directors. Committees that report to Executive Committee are listed in Appendix A.

PART C: CREATION OF STANDING OR SPECIAL COMMITTEES

The Executive Committee of the Medical Staff may, by resolution, without amendment to these Bylaws, establish a committee to perform one or more staff functions. In the same manner, the Executive Committee may, by resolution, dissolve or rearrange committee structure, duties, or composition as needed to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Executive Committee of the Medical Staff.

ARTICLE VI
MEMBERSHIP AND CLINICAL PRIVILEGES

PART A: NATURE OF MEMBERSHIP

Appointment to the Medical Staff of Methodist Jennie Edmundson is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. All persons practicing medicine, dentistry, or any other profession qualifying for privileges, if any, in the Hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff. Membership is granted by the Board following recommendation by the Medical Staff. Each member and each applicant for membership must meet, in addition to qualifications established for each category of membership, and departmental criteria for the exercise of privileges, the general qualifications for clinical privileges contained in these Bylaws.

PART B: CLINICAL PRIVILEGES

Section 1. Nature of Privileges. Privileges to practice at the Hospital are granted by the Board following recommendation of the Medical Staff. Application for or acceptance and exercise of privileges constitutes acceptance of the terms and conditions of these Bylaws and the Bylaws of the Hospital. The prerogatives attendant to holding privileges in this Hospital are expressly limited by the provisions of these Bylaws and the Bylaws of the Hospital. A practitioner may exercise only those clinical privileges specifically granted in accordance with these Bylaws.

Section 2. Qualifications. The following constitute continuing qualifications for the exercise of privileges at the Hospital. Each member and applicant for membership and clinical privileges shall:

(a) **Independent Practitioner**. Be an independent practitioner. An individual is an independent practitioner if:

(1) The practitioner is licensed to provide a defined body of health services by the state of Iowa and is currently eligible to provide services to Medicare and Medicaid beneficiaries;

(2) The practitioner has authority, by virtue of licensure and other relevant laws, to receive and examine patients, diagnose conditions, prescribe and implement a treatment plan, and prescribe all medications necessary for the treatment of conditions and diagnoses within the practitioner's area of practice, independent of review, or supervision of prescription by another practitioner.

(b) **Authority Over Staff**. Be authorized by law to independently give binding directions to nursing and other Hospital staff such that all staff, when carrying out such directions in the Hospital, will do so on lawful authority.

(c) **Residency**. Have successfully completed a minimum three-year post-graduate clinical residency, fellowship or internship (or combination thereof) in a relevant specialty which qualifies the applicant to become Board Certified.

(d) **Nature of Practice**. Practice a health care specialty which is consistent with the purposes, treatment philosophy, methods, and resources of the Hospital and its medical and professional staff.

(e) **Reimbursement**. Be licensed in a specialty which generally assures the Hospital that services initiated by or under the authority of such practitioner will be recognized as medically necessary patient care services under the Review Plan of the Quality Improvement Review Organization, and be reimbursable under federal health care programs, and private insurers.

(f) **Licensure**. Be currently licensed by the State of Iowa to practice his profession and to exercise the privileges held or applied for; and be currently registered by the Drug Enforcement Administration (D.E.A.) and state to prescribe medications consistent with the clinical privileges held or applied for, unless a waiver is granted.

(g) **Ethics**. Strictly abide by the ethics of his profession, and avoid acts and omissions constituting unprofessional conduct under state licensing laws and regulations or fraud or other actionable conduct potentially subject to penalty or criminal sanction under the Medicare/Medicaid fraud and abuse guidelines or other state or federal laws.

(h) **Health**. Be free of or have under adequate control any significant physical, mental or behavioral health condition that would prevent the practitioner from performing all of the essential functions required for safe and effective exercise of professional responsibilities without posing a threat to patients.

(i) **Health Assessment**. Cooperate openly and fully in any health assessment which may be required by the Executive Committee under Article VII, Part E.

(j) **Professional Liability Coverage**. Maintain in full force and effect valid coverage for personal professional liability in an amount not less than that established by the Board, from time to time, following consultation with the

Medical Staff, and document such coverage to the satisfaction of the Hospital in the form and manner prescribed.

(k) **Information**. Provide accurate, current, and thorough information in connection with the appointment, or in response to inquiries from the Executive Committee or the Board.

(l) **Continuous Care**. Unless expressly waived by the Credentials Committee and Executive Committee, each applicant must designate an alternate practitioner in the applicant's field and specialty who has privileges at MJEH at least coextensive with those held or applied for by the applicant and who has an agreement with the applicant to provide coverage to patients of the applicant when the applicant is unavailable.

(m) **Observation**. Perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact with the Hospital to permit the Medical Staff to assess current competency for all requested privileges during the provisional period or thereafter. Because the means of assessing performance will vary greatly from practitioner to practitioner and from category to category, observing practitioners will collaborate with the Credentials Committee to choose appropriate tools for monitoring.

(n) **Competence**. Demonstrate current competence in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts and consistent with available resources.

(o) **Documentation**. Document the foregoing qualifications to the satisfaction of the Board and Medical Staff. The practitioner shall have the burden of establishing that he or she meets all eligibility requirements, qualifications, and conditions for the exercise of privileges.

The foregoing qualifications shall not be deemed exclusive if other qualifications and conditions are also relevant to considering an application or granting or exercising privileges in the Hospital.

Only practitioners who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character, and their ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive quality medical care and that the Hospital and its Medical Staff will be able to operate in an orderly manner shall be qualified for appointment to the Medical Staff. The word "character" is intended to include the applicant's mental and emotional stability.

No practitioner shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice his profession in Iowa or any other state, or that he is a member of any particular professional organization, or that he is Board certified in a particular specialty, or that he had in the past, or currently has, medical staff appointment or privileges in another hospital. No practitioner shall be denied appointment on the basis of sex, race, creed, disability, color or national origin.

Section 3. Waiver. The foregoing Section 2(c), requiring that the practitioner have completed a required residency or fellowship, shall not be applicable with respect to practitioners holding membership and privileges on the date the requirement is adopted, or with respect to practitioners who are board certified in the field in which privileges are requested or have demonstrated equivalent clinical experience.

PART C: CONDITIONS AND DURATION OF APPOINTMENT

Section 1. Provisional Appointment. All initial appointments to Medical Staff membership shall be to the Provisional Staff as described in Article II, Part A. All initial clinical privileges shall be provisional for a period of not less than eighteen (18) months nor longer than twenty-four (24) months from the date of the appointment. During the term of this provisional appointment, the person receiving this provisional appointment shall be evaluated by the chairman of the department or departments in which he has clinical privileges, and by the relevant committees of the Medical Staff and the Hospital as to his clinical competence and as to his general behavior and conduct in the Hospital. Clinical privileges may be adjusted to reflect the results of observation during the provisional period, at the end of the provisional period, or sooner if warranted. The practitioner remains an applicant throughout the period of provisional appointment and will receive regular appointment at the conclusion of the provisional period only if he meets the qualifications of Article VI, Part B. Appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article VI, Part K, Section 2 of these Bylaws. During initial provisional appointment, the applicant may not vote, hold office, or chair departments or committees of the Medical Staff, regardless of staff category unless the individual practitioner is specifically authorized by the Executive Committee according to criteria set forth in Medical Staff policies.

Section 2. Duration of Reappointment. Reappointment shall be for a maximum period of two (2) years.

Section 3. Leave of Absence. Any practitioner who anticipates being absent from his practice at the Hospital may request a leave of absence from the Medical Staff by following the procedures set out in Article VII, Part D of these Bylaws.

Section 4. Duties of Appointees.

(a) **Support of Corporate Compliance**. Participate in and actively support corporate compliance activities as requested by the Hospital, including but not limited to attendance at compliance education and training, participation in compliance committee meetings, and adherence to legal requirements and compliance standards and plans applicable to the practitioner's practice.

(b) **Cooperation with Peer Review**. Cooperate in any peer review process or review of his or her (or another's) credentials, qualifications, or compliance with these Bylaws, including by providing office records or records from other institutions if requested, and refrain from directly or indirectly obstructing any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise.

(c) **Utilization Management**. Work cooperatively with the Comprehensive Review Committee, and Administration to meet and practice within the guidelines and Review Plan established by the Hospital or the Quality Improvement Organization (QIO), to minimize or eliminate disallowed admissions, to eliminate technical diagnosis entry and coding errors, to order or utilize supporting and

ancillary services only when necessary, and to shorten lengths of stay at the Hospital where medically appropriate.

(d) **Confidentiality**. Maintain the confidentiality of patient clinical information and of the minutes, records, and work product of Medical Staff committees engaged in the peer review process. This provision shall not prohibit mandatory disclosures under state or federal law, nor disclosures required under these Bylaws, nor disclosures to professional associations or bodies made in the context of peer review.

(e) **Staying Within Practice Limits**. Strictly refrain from performing any procedures, assuming any patient care responsibilities, or applying for or exercising any specific privileges for which such individual is not licensed, currently trained, and currently qualified.

(f) **Compliance with Rules**. Abide by the terms, conditions, and procedures of these Bylaws and the governing documents and policies of the Hospital.

(g) **Responsibilities**. Consistently carry out assigned patient care, committee, and staff responsibilities, and work cooperatively and responsibly with colleagues, the Medical Staff, the Hospital, and its administrative and professional staff.

(h) **Records**. Complete all required patient care records in a thorough, professional and timely fashion.

(i) **Cooperative Working Relationships**. Exhibit a willingness and a capability, based on current attitude and evidence of performance, to work with and relate to other Medical Staff members, members of other health disciplines, Hospital administration and employees, the Board, patients, family members, visitors; and the community in general, in a cooperative, professional, non-disruptive manner that is essential for maintaining an environment appropriate to quality and efficient patient care.

(j) **References**. Furnish favorable recommendations from proctors (where proctors are appointed) as requested by the Credentials Committee and from professional colleagues who are in a position to observe and form an informed opinion about the practitioner's qualifications.

(k) **OHCA**. Qualify to participate in Hospital health care operations, such as Hospital and Medical Staff quality improvement, utilization management, peer review and other functions requiring use of protected health information, either as a member of the workforce, a participant in an organized health care arrangement with the Hospital or by executing a business associate agreement. Qualification under this standard is described in the Rules and Regulations.

(l) **Focused and Ongoing Professional Practice Evaluations**. Cooperate with the processes developed by the Hospital and the Medical Staff for focused and ongoing professional practice evaluations.

PART D: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Information. Applications for appointment to the Medical Staff shall be in writing and shall be submitted on forms prescribed by the Board after consultation with the Executive

Committee. These forms shall be obtained from the President or his designee. The application shall require detailed information establishing that the applicant meets all of the qualifications for membership and privileges as contained within these Bylaws, and also including:

(a) The payment by or on behalf of the practitioner of any sum in judgment, settlement or compromise based upon alleged professional negligence;

(b) Any change in the status, amount or coverage of professional liability insurance coverage as stated in Article VI;

(c) Successful or currently pending challenges to any licensure or registration;

(d) Any voluntary or involuntary relinquishment of such licensure or registration;

(e) Voluntary or involuntary termination, limitation, reduction or loss of clinical privileges, or denial of requested privileges at any other hospital;

(f) Exclusion from providing services to beneficiaries under the Medicare and Medicaid programs;

(g) Voluntary or involuntary termination of medical staff membership at any other hospital; and

(h) Health status.

Section 2. Binding Effect. Every application for staff appointment shall be signed by the applicant and shall bind the applicant to the Bylaws, Rules and Regulations of the Medical Staff.

Section 3. Burden of Providing Information. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of his current competence, character, ethics, and other qualifications and for resolving any doubts about any of the above. He shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.

Section 4. Incomplete Applications. 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 adequate responses from references have been received. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. An incomplete application will not be processed. Any application that continues to be incomplete one hundred twenty (120) days after the individual has been notified of the additional information required shall be deemed to be withdrawn and all rights under Article VIII (Hearing and Appeal Procedures) shall be deemed waived and none of the procedures under Article VIII shall apply. A deemed withdrawal may be waived by the Credentials Committee upon further review if complete information has been supplied. Practitioners shall immediately provide notice of any change in the status of any condition that would alter any response to any question asked in the application. By applying for appointment to the Medical Staff, each applicant signifies his willingness to appear for interviews in regard to his application.

Section 5. Verification. In addition to verifying application information with primary sources, the Hospital will query the National Practitioner Data Bank and other background checking sources as required by law or by policy of the Hospital or Medical Staff, including but not limited to the OIG List of Excluded Individuals and Entities and the GSA List of Individuals and Entities

Barred from Procurement and Non-Procurement Programs. In addition, the Hospital may query the American Medical Association or other background checking sources as determined by policy and practice of the Hospital or Medical Staff.

PART E: AUTHORIZATION AND RELEASE

Section 1. Interpretation. It is the intention of these Bylaws to define the term peer review in the broadest terms and to secure to those who engage in any aspect of peer review in, at, for, or on behalf of the Hospital and its Medical Staff, the broadest possible privilege and immunity from liability. This Article VI and these Bylaws will be interpreted to effectuate this objective. The privileges and immunities set forth in this Article VI shall be cumulative and in addition to other protections provided by law.

Section 2. Authorization and Release. The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his application, whether or not he is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment. Each applicant and each appointee hereby expressly:

(a) **Authorizes** this Hospital and its authorized representatives to request, receive, furnish, discuss, consider, and act upon all relevant information bearing upon such practitioner's qualifications or performance;

(b) **Releases from liability**, to the fullest extent permitted by law, this Hospital and its authorized representatives for requesting, receiving, considering, discussing, furnishing, or acting upon information as authorized above in connection with the peer review functions of this Hospital and its Medical Staff;

(c) **Authorizes** and directs any other hospital, institution, organization, or individual to furnish information, and releases from liability any such hospital, institution, organization, or individual for furnishing such information, when reasonably believed to relate to the peer review responsibilities of this Hospital and its Medical Staff;

(d) **Agrees** to furnish all information in his possession regarding any other practitioner in connection with, and to participate according to assigned responsibilities under these Bylaws, in the peer review functions of this Hospital and its Medical Staff; and

(e) **Pledges** to maintain the confidentiality of the minutes, records, and work product of the Hospital and its Medical Staff related to peer review. This provision will not be construed to prohibit mandatory disclosures under these Bylaws or disclosures to government or professional associations made in the context of peer review.

(f) **Definitions**.

(1) As used in this section, the term "Hospital and its authorized representatives" means Methodist Jennie Edmundson, Women's Christian Association, Nebraska Methodist Health System, members of

their Boards and their appointed representatives, the President or his designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his partners, associates or designees, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials or acting upon his application or conduct in the Hospital.

(2) As used in this section, the term "third parties" means all individuals, including appointees to the Hospital's Medical Staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses, or other organizations, associations, partnerships, and corporations, or government agencies, whether hospitals, health care facilities, or not, from whom information has been requested by the Hospital or its authorized representatives.

(3) As used in this section, the term "peer review" means evaluation of professional services rendered by a person licensed to practice a health care profession.

Section 3. Scope of Peer Review. Each officer, department, and committee of the Medical Staff is hereby constituted a peer review body and assigned peer review responsibility within the Hospital consistent with his or its charge. Each such officer, department, and committee, plus their agents (including the President and his designees) are directed to engage in peer review activity and to investigate and make recommendations to the Executive Committee concerning applicants or members of the Medical Staff on all matters coming to their attention and within their areas of primary or delegated responsibility, reflecting adversely on the credentials, performance, quality of practice, or quality of patient care, or suggesting violation of these Medical Staff Bylaws. Each other practitioner or officer or employee of the Hospital, and each other committee of the Medical Staff, shall furnish such investigating body or committee with such requested information as is in his or its possession which bears on the matter under investigation.

Section 4. Attendance at Mandatory Meetings.

(a) Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular departmental meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, the chairman of the department shall give him advance written notice of the time and place of the meeting at which his attendance is expected. Attendance at the meeting shall be mandatory if the chairman of the department determines that the meeting is necessary to discuss apparent or suspected deviation from standard clinical practice and so advises the practitioner in the written notice. If the individual shall make a timely request for postponement supported by an adequate showing that his absence will be unavoidable, the presentation may be postponed by the chairman of his department or by the Executive Committee if the department chairman is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

(b) The chairman of the applicable department shall notify the Executive Committee of the failure of an individual to attend any meeting with respect to which he was given notice that attendance was mandatory. Unless excused by the Executive

Committee for good cause, such failure shall result in an automatic suspension of all or such portion of the individual's admitting or practice privileges as the Executive Committee may direct. Such suspension shall remain in effect until the practitioner attends an alternate meeting or until the matter is otherwise resolved.

Section 5. Information Privileged. All statements, disclosures, reports, recommendations, and other communications made in connection with peer review activities of the Hospital shall, to the fullest extent permitted by law, be confidential and privileged from further disclosure, except as otherwise provided in these Bylaws.

PART F: DESCRIPTION OF INITIAL CLINICAL PRIVILEGES

Section 1. Application for Clinical Privileges. Recommendations of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

Section 2. Surgical Privileges for Non-physicians. The scope and extent of surgical procedures that a dentist or other non-physicians may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists or other non-physicians shall be under the overall supervision of the Chairman of the Department of Surgical Services. A medical history and physical examination of the patient shall be made and recorded by a physician with admitting privileges before surgery is performed, and a designated physician with admitting privileges shall be responsible for the medical care of the patient throughout the period of hospitalization.

PART G: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Credentials Committee Procedure.

(a) Upon receipt of the completed application for appointment from the President, the Credentials Committee shall post the name of the applicant in a conspicuous place in the Medical Staff lounge so that each person appointed to the Medical Staff may have an opportunity to submit to the committee, in writing, information bearing on the applicant's qualifications for staff appointment. In addition, any person appointed to the Medical Staff shall have the right to appear in person before the Executive Committee to discuss in private and in confidence any concerns he may have about the applicant.

(b) The applicant's experience, ability, and current competence in performing the requested privileges are verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment of proficiency in the following six areas of "general competencies adopted from the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties joint initiative:

(i) **Patient Care**. Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

(ii) **Clinical/Medical Knowledge**. Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social

sciences, and the application of such knowledge to patient care and the education of others.

(iii) **Practice-based Learning and Improvement**. Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

(iv) **Interpersonal and Communication Skills**. Practitioners are expected to demonstrate interpersonal and communication skills that will enable them to establish and maintain professional relationships with patients, families, and other members of the health care teams.

(v) **Professionalism**. Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their profession and society.

(vi) **Systems-based Practice**. Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

(c) The chairman of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges, and these recommendations shall be made a part of the report. As part of the process of making this recommendation, the department chairman may meet with the applicant to discuss any aspect of his application, his qualifications, and his requested clinical privileges.

(d) Where appropriate, as part of the consideration, the department or the Credentials Committee shall consider the resources, equipment, and types of personnel necessary to support a requested privilege and may delay approval of privileges until any issues relating to necessary resources, equipment, and personnel are resolved.

(e) All new applicants for clinical privileges will undergo a focused professional practice evaluation pursuant to criteria determined by the Credentials Committee and governed by the MJE "Focused & Ongoing Professional Practice Evaluation" Administrative Policy.

(f) Within ninety (90) days after receipt of the completed application for appointment from the President, the Credentials Committee shall forward the file to the Executive Committee.

Section 2. Executive Committee Procedure.

(a) At its next regular meeting after receipt of the application, report and recommendation of the department chairman and the Credentials Committee, the Executive Committee shall determine whether to recommend to the Board that the applicant be provisionally appointed to the Medical Staff, that his application be deferred for further consideration, or that he be rejected for staff appointment.

(b) When the recommendation of the Executive Committee is favorable to the applicant, the President shall promptly forward it, with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.

(c) When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for appointment to the Medical Staff with specific clinical privileges or for rejection of the application for staff appointment.

(d) When the recommendation of the Executive Committee is adverse to the applicant in respect to either appointment or clinical privileges, the President shall promptly so notify the applicant by certified mail, return receipt requested. The Executive Committee shall then hold the application until after the applicant has exercised or has been deemed to have waived his right to a hearing as provided in Article VIII. Whenever the applicant has been deemed to have waived his right to a hearing, the President shall forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. If the applicant requests a hearing, the recommendation of the Hearing Committee appointed under Article VIII shall be forwarded to the Executive Committee.

(e) If, after the Executive Committee has considered the report and recommendation of the Hearing Committee and the hearing record, the Executive Committee's reconsideration recommendation is favorable to the applicant, the President shall promptly forward it, together with all supporting documentation, to the Board. If such recommendation continues to be adverse, the President shall promptly notify the applicant by certified mail, return receipt requested. The President shall then forward such recommendation, together with all supporting documentation, to the Board. Alternatively, applicants meeting the standards for an expedited process set out in subparagraph (f) of this Section, may be referred to the Medical Staff Committee of the Board.

(f) **Expedited Process**. A Medical Staff Committee authorized by the Board, comprised of a minimum of three (3) directors and appointed in accordance with the Hospital Bylaws, may, in appropriate instances, review the credentialing functions of the Medical Staff and the recommendations of the Executive Committee to the Board regarding appointment and reappointment of, and the gravity of reviewing of clinical privileges to, qualified and duly licensed practitioners. The Medical Staff Committee shall report its decisions and recommendations to the Board. The Board, through its Bylaws, has authorized the Medical Staff Committee to render decisions regarding the appointment, reappointment, and the granting or renewal of privileges in cases in which there is a positive recommendation from the Executive Committee on a complete application.

In addition to a positive recommendation from the Medical Executive Committee applications for appointment or reappointment must also be free of:

(i) A current or previously successful challenge to licensure;

(ii) Involuntary termination of Medical Staff membership at another organization;

(iii) Involuntary limitation, reduction, denial or loss of clinical privileges; or

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

(g) The Executive Committee, after consideration of the recommendation of the department chairman as transmitted through the Credentials Committee, shall recommend initial departmental assignments for all appointees to the Medical Staff and for all other approved individuals with clinical privileges.

Section 3. Duration. Initial appointment, privileges, and each reappointment thereafter, will be for a period of no more than two (2) years.

PART H: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary Privileges. Temporary privileges constitute temporary permission to attend a patient at the Hospital. Temporary privileges are distinguished from privileges of the Hospital in that they are not based upon a complete review of credentials. All practitioners using the Hospital are expected to apply for and obtain regular clinical privileges. A practitioner requesting temporary privileges, in addition to establishing qualifications, must demonstrate a compelling need for temporary privileges. Temporary privileges may be granted or revoked by the President or his designee after consultation with the department chairman or Chief of Staff. Temporary privileges may be revoked or withdrawn at any time, with or without cause, without recourse by the practitioner to the hearing and appeals procedure of Article VIII. Temporary privileges are granted under the following circumstances and subject to the following conditions:

(a) **Circumstances**. There are two circumstances in which temporary privileges may be granted. Temporary privileges may be granted as follows for a period not to exceed one hundred and twenty (120) days:

(1) When a new applicant with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Board. Prior to granting temporary privileges on this basis, the following verifications shall be completed:

(i) Current unrestricted Iowa license;

(ii) Relevant training and experience;

(iii) Current competence;

(iv) Ability to perform the privileges requested;

(v) No current or previous successful challenge to licensure;

(vi) No involuntary termination of Medical Staff membership at another organization;'

(vii) No involuntary limitation, reduction, or loss of clinical privileges;

(viii) Proof of current professional liability coverage;

(ix) Proof of DEA registrations, federal and state; and

(x) Satisfactory query of the National Practitioner Data Bank.

(2) To fulfill an important patient care or service needed. When temporary privileges are requested on this basis, current state licensure and current competence shall be verified before privileges are granted. In addition, proof of current professional liability coverage and a satisfactory query of the National Practitioner Data Bank will be obtained.

(b) **Application**. An applicant for temporary privileges must submit an application and supporting documentation on a form and in a manner approved by the Executive Committee.

Section 2. Termination of Temporary Clinical Privileges.

(a) The President or, in his absence, his designee may at any time, after asking for a recommendation of the Chief of Staff or the chairman of the department responsible for the individual's supervision, terminate an individual's temporary admitting and clinical privileges.

(b) The appropriate department chairman, or in his absence, the Chief of Staff shall assign to a Medical Staff appointee responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, given consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) Temporary privileges of an applicant shall be automatically terminated when the department chairman provides unfavorable recommendation to the applicant's appointment to the staff. At the Executive Committee's discretion, temporary privileges shall be modified to conform to the recommendation of the department chairman that the applicant be granted different permanent privileges from the temporary privileges.

Section 3. Limitation on Prerogatives. Temporary privileges are limited, temporary permission to render specific patient care services in the Hospital. A practitioner holding temporary privileges is not a member of the Medical Staff, acquires no membership rights and/or interests, and is not considered "privileged" for any purpose other than for a particular case or episode of care or a time-limited period of service. A practitioner exercising temporary privileges shall not be deemed to have joined the Medical Staff. Upon the expiration of temporary privileges, a practitioner has no continuing rights, status, or privileges on the Medical Staff. Temporary privileges granted to licensed medical residents and fellows shall not imply that the practitioner has committed practicing in the geographic area served by the Hospital following the episode of care or coverage for which temporary privileges are granted.

Section 4. *Locum Tenens*. Physicians serving as *locum tenens* for a member of the Medical Staff are subject to the temporary privileging requirements set forth in this Part H(1)(a)(1) above.

PART I: EMERGENCY AUTHORITY

Section 1. Particular Patients. In any emergency involving a particular patient, a physician or dentist who is not currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable. Similarly, in an emergency involving a particular patient, a physician or dentist currently appointed to the Medical Staff may be permitted by the Hospital to exercise authority not specifically assigned to him in the form of privileges to act in such an emergency.

When the emergency situation no longer exists, such physician or dentist must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he does not request such privileges, the patient shall be assigned to an appropriate person currently appointed to the Medical Staff.

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

Section 2. Disaster Privileging. In the event of a disaster, mass casualty and/or terrorism, emergency privileging of additional practitioners to assist members of the Medical Staff may be needed immediately when the Hospital's emergency management plan has been activated and the Hospital requires additional assistance to meet immediate patient needs. Practitioners who request disaster credentialing must be currently licensed practitioners who maintain equivalent privileges at another facility. Privileges requested should be consistent with those currently in place in the appropriate department and specialty at the practitioner's "home" hospital. The practitioner requesting disaster credentialing must provide a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) AND at least one of the following:

(a) A current picture hospital identification card that clearly identifies professional designation.

(b) A current license to practice.

(c) Primary source verification of his or her license.

(d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

(d) Identification indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.

(e) Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's ability to act as a practitioner during a disaster.

The President or his designee and/or the chairman of the Executive Committee may grant immediate disaster privileges. The President or his designee and/or the chairman of the Executive Committee are not required to grant privileges to any requestor, rather all such decisions shall be made on a case-by-case basis at the discretion of the President or his

designee and/or the chairman of the Executive Committee. Disaster privileges shall be effective immediately and continue through the completion of the patient care needs or until the orderly transfer of the patient's care to another regularly credentialed physician can be accomplished.

The Vice President of Medical Affairs or his designee shall monitor the performance of those granted disaster privileges through direct observation for disasters of short duration and through direct observation and medical record review for other disasters.

Any physician granted privileges shall be provided with and maintain on his or her person written verification of said privileges. In addition, any practitioner granted disaster privileges shall be provided with an ID or name tag identifying him or her as being affiliated with the Hospital.

As soon as practical, verification of the disaster-credentialed physician should be undertaken. This verification should include, at a minimum:

(a) Current and unencumbered medical licensure primary source verification;

(b) DEA and state narcotics registration;

(c) National Practitioner Data Bank discovery;

(d) Health and Human Services/Office of Inspector General (HHS/OIG) List of Parties Excluded from Federal Programs;

(e) One current active hospital affiliation;

(f) Malpractice insurance coverage; and

(g) Primary source verification of current competency.

The President or his designee and/or Chairman of the Executive Committee may terminate disaster privileges at any time. The President or his designee and/or Chairman of the Executive Committee will determine within each 72 hour period following the disaster whether privileges initially granted should continue.

Definitions

Disaster – A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demand for health care.

Mass Casualty – An accidental or intentional event causing injury or death to multiple victims.

Terrorism – The unlawful use of force or violence committed by a group(s) of two or more individuals against persons or property to intimidate or coerce the government, the civilian population, or any segment thereof, in furtherance of political or social objectives. Bioterrorism is the use of microorganisms or their toxins to produce death or disease in humans for the same objectives.

PART J: HARVESTING OF ORGANS

Authority may be granted to any practitioner qualified to harvest organs or tissue, who has been approved by any organ retrieval program affiliated with the Hospital, to do so whether or not the practitioner has other clinical privileges at the Hospital.

PART K: TELEMEDICINE PRIVILEGES

Practitioners who, via telemedicine, prescribe, render a diagnosis (including image interpretations) or otherwise provide clinical treatment to patients at MJEH shall be credentialed and privileged in accordance with these Bylaws. In cases in which the practitioner is credentialed at a distant site hospital or telemedicine entity with a written agreement with MJEH to provide telemedicine services to MJEH patients, the Medical Staff may, at its discretion, rely upon information provided by the distant-site hospital or telemedicine entity. However, at a minimum, the National Practitioner Data Bank must be queried and the applicant must sign authorizations and releases pertinent to MJEH and the application and related documents shall be reviewed by the Department Chair, the Credentials Committee, be recommended by the Medical Executive Committee and approved by the Board in order to be valid. Temporary privileges may be granted to telemedicine practitioners and applications may be reviewed and approved under the expedited process set out at Article VI, Part G(g), if eligible.

PART L: ADMINISTRATIVE/CONTRACT PHYSICIANS

Certain practitioners provide services as employed Medico-administrative officers or under contract to the Hospital. Such administrative and contract practitioners must first qualify for and obtain clinical privileges in their area in the same manner as other practitioners. If the contract or terms of appointment of any such administrative or contract practitioner so provide, the practitioner's Medical Staff membership and privileges may be conditioned on continued appointment or contract with the Hospital.

PART M: ADMITTING AND CO-ADMITTING PRIVILEGES

Section 1. Co-Admitting Privileges. Co-admitting privileges are a clinical privilege of the Hospital granted to qualified practitioners the same as any other privileges. Co-admitting privileges entitle the practitioner to admit a patient to the Hospital for treatment within such individual's area of licensure, subject to designating a physician member of the Medical Staff with admitting privileges to assume responsibility for medical evaluation, history and physical examination, and overall medical responsibility for the patient's course of care in the Hospital. The practitioner with co-admitting privileges shall be responsible for making suitable arrangements with the physician member of the Medical Staff designated at the time of admission to assure prompt medical evaluation and assumption of responsibility. Non-physician practitioners may perform that part of the history and physical exam pertaining to their field. In order to be eligible for co-admitting privileges, the practitioner must:

(a) Meet all the criteria for clinical privileges of the Hospital.

(b) Be licensed in a health care specialty which is authorized to diagnose and treat conditions which regularly and routinely require hospitalization because of the severity, complexity or risk factors associated with such conditions themselves.

(c) Meet such other conditions as are recommended by the Medical Staff and approved by the Board.

Section 2. Admitting Privileges. Admitting privileges are a clinical privilege of the Hospital, granted to qualified practitioners in the same manner as other privileges. In order to be eligible for admitting privileges, the practitioner must:

(a) Qualify for co-admitting privileges.

(b) Be licensed in an area which generally assures the Hospital that inpatient Hospital care including overnight hospitalization, ancillary services, tests, pharmaceutical agents, and supplies, ordered and certified to by such practitioner, will be recognized as medically necessary and reimbursable under Medicare, Medicaid, Blue Cross, and other payment programs.

(c) Be authorized by law to prescribe or approve medications which patients may bring with them into the Hospital.

(d) Be authorized by licensure to independently perform medical evaluation, including a history and physical examination, and to assume overall responsibility for a patient's care in the Hospital. The history and physical must be completed within twenty-four (24) hours of admission on all inpatient and observation admissions, and on all inpatient and outpatient surgery patients prior to the surgical procedure if: anesthesia/sedation is to be administered or when an outpatient diagnostic procedure is performed with moderate or deep sedation or under anesthesia (excluding local anesthesia). The history and physical examination shall also be performed prior to surgery as required by third party payors (e.g., local medical review policy). If a thorough history and physical has been completed within thirty (30) days prior to admission, a durable, legible copy of the report may be placed in the patient’s medical record, provided that an update is documented within twenty-four (24) hours prior to the surgical procedure by a practitioner with appropriate privileges.

(e) Reside in sufficient proximity to the Hospital to assure that any patient admitted by them will receive continuous care.

(f) Meet such other conditions as are adopted by the Medical Staff and approved by the Board.

PART N: PROCEDURE FOR REAPPOINTMENT

Section 1. When Application is Required.

(a) At least sixty (60) days prior to the expiration of a practitioner's appointment, the practitioner shall be sent an application on which to request reappointment, a listing of the privileges the applicant then holds, and a delineation of privileges form. The application shall be a form prescribed by the Board after consultation with the Executive Committee. The application form, once adopted, shall constitute a part of the Rules and Regulations of the Medical Staff. Any person who, at that time, wishes to be considered for a change in his Medical Staff category or a change in his clinical privileges or who does not desire reappointment shall so indicate on the appropriate form and submit it to the President. The chairman of the clinical department may request a meeting with the practitioner to review the privilege listing and the practitioner may modify his application at any time thereafter until the department chairman makes a recommendation for privileges through the Credentials Committee to the

Executive Committee. Reappointments to the Medical Staff shall be for a period of no more than two (2) Medical Staff Years. The appointment or reappointment and the granting of clinical privileges in any one (1) term creates no presumption or expectation of renewal.

(b) Each current appointee who wishes to be reappointed shall be responsible for completing his application for reappointment. The application shall request details about any material changes in information given or the status of the practitioner since last appointed or reappointed, including:

(i) The payment by or on behalf of the practitioner of any sum in judgment, settlement or compromise based upon alleged professional negligence;

(ii) Any change in the status, amount or coverage of professional liability insurance coverage as stated in Article VI;

(iii) Successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration;

(iv) Voluntary or involuntary termination, limitation, reduction or loss of clinical privileges at any other hospital;

(v) Exclusion from providing services to beneficiaries under Medicare and Medicaid programs;

(vi) Any change in health status; and

(vii) Voluntary or involuntary termination of medical staff membership at any other hospital.

(c) Requests for renewal of privileges must specifically list the privileges being requested, including admitting privileges. Applicants may not simply indicate that they wish to receive the same privileges as were granted in the prior appointment period. The Department Chairman or Credentials Committee will review individuals' privilege lists and may, in his or its discretion, meet with the practitioner if the practitioner is requesting renewal of unused privileges or for which there may be an issue of training or experience.

Section 2. Factors to be Considered. Each recommendation concerning reappointment to the Medical Staff, renewal of privileges, enlargement of privileges, or a change in staff category, where applicable, shall be based upon the qualifications in Article VI, Part B, including:

(a) Professional ethics, competence, and clinical judgment in the treatment of patients.

(b) Attendance at Medical Staff meetings and participation in staff affairs.

(c) Compliance with the Hospital Bylaws and policies and the Medical Staff Bylaws, Rules and Regulations.

(d) Behavior and cooperation with Hospital personnel.

(e) Use of the Hospital's facilities for patients, cooperation and relations with other practitioners, and general attitude toward patients, the Hospital, and the public.

(f) Physical or mental health.

(g) Satisfactory completion of continuing education requirements.

(h) Results of performance improvement findings, utilization review, peer review, and other studies.

(i) Findings of ongoing professional practice evaluations conducted during the prior period.

Section 3. Department Procedure.

(a) The President shall send to the departmental chairman the files of those appointees desiring reappointment. The department chairman shall review all pertinent information from other committees of the Medical Staff and from Hospital Administration for the purpose of determining a recommendation for staff reappointment, for change in staff category, and for granting of clinical privileges. The departmental chairman may elect to refer the reapplication to the departmental review committee for a recommendation.

(b) The department chairman shall forward a report and recommendation to the Credentials Committee. When the department chairman's report is adverse to the applicant, the reason for such recommendation shall be documented in the report. The chairman of the department or his designee shall be available to the Credentials Committee or to the Board or its appropriate committee to answer any question that may be raised with respect to the recommendation.

Section 4. Executive Committee Procedure.

(a) The Executive Committee, after receiving recommendations from the chairman of each department and the Credentials Committee, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from Hospital Administration management for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing year.

(b) Upon receipt and consideration of departmental and Credentials Committee recommendations, the Executive Committee shall make written recommendations to the Board concerning the reappointment, clinical privileges, and, where applicable, change in staff category of each person currently holding a Medical Staff appointment.

(c) Where non-reappointment or non-promotion or a reduction in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented and included in the report.

Section 5. Procedure Thereafter. Any recommendation by the Executive Committee described in Article VIII, Part A, Section 1, shall entitle the affected practitioner to the procedural rights provided in Article VIII. The President shall then promptly notify the practitioner of the recommendation by certified mail, return receipt requested. The recommendation shall not be

forwarded to the Board until the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article VIII, after which the Board shall be given the committee's final recommendation and shall act on it unless appropriate for the expedited process set forth at Article VI, Part G, Section 2(f) above.

PART O: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

Section 1. Application for Increased Clinical Privileges. Whenever, during the term of his appointment to the Medical Staff, or at the time of applying for reappointment, a practitioner desires to increase his clinical privileges, he shall apply in writing to the President on a form prescribed by the Board. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justifies increased privileges. This application will be transmitted by the President to the appropriate department or the Credentials Committee. Where appropriate, as part of the consideration, the department or the Credentials Committee shall consider the resources, equipment, and types of personnel necessary to support a requested privilege. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment or as a part of the reappointment application, if the request is made at that time.

Section 2. Supervision. The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such period of time as are thought necessary.

Section 3. Focused Professional Practice Evaluation. Any practitioner requesting an increase in clinical privileges will undergo a focused professional practice evaluation pursuant to criteria determined by the Credentials Committee and governed by the MJE "Focused & Ongoing Professional Practice Evaluation" Administrative Policy.

PART P: RECLASSIFICATION

A current member of the Medical Staff desiring reclassification to another category of staff shall submit a written request to the Medical Staff office. The member's eligibility for reclassification will be based upon whether the member is meeting all the requirements for the category of staff requested. A denial of a request for reclassification based on failure to meet the qualifications of the requested category does not trigger hearing and appeal rights.

PART Q: WAIVER

Section 1. Medical Staff Bylaws Exception. Any individual who seeks an exception to the medical staff bylaws in regard to privileging and/or credentialing criteria may request a waiver, in writing. The individual requesting a waiver bears the burden of demonstrating exceptional circumstances, and that his qualifications are equivalent to, or exceed, the criterion in question.

Section 2. Request for waiver.

(a) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and/or other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Executive Committee of the Medical Staff.

(b) The Executive Committee will review the recommendation of the Credentials Committee. The Executive Committee may, by a majority vote, make a recommendation to the Board regarding whether to grant the request for a waiver.

(c) Any recommendation to grant a waiver must include the basis for the request.

(d) No individual is entitled to a waiver or to a hearing if the Executive Committee or Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

ARTICLE VII
ACTIONS AFFECTING MEMBERS; CORRECTIVE ACTION

PART A: CORRECTIVE ACTION

Section 1. Corrective Action. Corrective action consists of action to discipline, restrict, suspend or limit a practitioner in a manner that adversely affects membership or privileges. However initiated or investigated, only corrective actions described in Article VIII, Part A, Section 1, entitle a practitioner to a hearing and appeal under these Bylaws.

Section 2. Grounds for Action. Whenever, on the basis of information and belief, the Chief of Staff, the chairman of a clinical department, a majority of the Executive Committee, the chairman of any other committee or a majority of that committee, the Chairman of the Board, or the President has cause to question with respect to a practitioner holding a current Medical Staff appointment whether such practitioner has failed or ceased to meet any of the qualifications for appointment and privileges or has violated the Bylaws or Rules and Regulations or the Bylaws or policies of the Hospital, a written request for an investigation of the matter shall be addressed to the Executive Committee making specific reference to the activity or conduct which gave rise to the request.

Section 3. Investigation. Investigation by the Medical Staff is a formal process of review. If the Executive Committee concludes an investigation is warranted, it shall document the decision to initiate an investigation in the minutes and notify the affected practitioner in writing that an investigation has been initiated.

Section 4. Corrective Action Procedure. The Executive Committee shall meet as soon after receiving the request for corrective action as practicable and if, in the opinion of the Executive Committee:

(a) The request to informally review the matter contains information sufficient to warrant a recommendation, the Executive Committee, at its discretion, shall make one, with or without a personal interview with the staff member; or

(b) The request to informally review the matter does not at that point contain information sufficient to warrant a recommendation, the Executive Committee shall immediately informally review the matter, appoint a subcommittee to do so, or, if it is deemed necessary, initiate an investigation and appoint an Investigating

Committee. This Investigating Committee shall consist of three persons of which at least two must be physicians. This Committee shall not include partners or associates of the affected practitioner and shall not include any members of the Executive Committee. The Executive Committee, its subcommittee, or the Investigating Committee, if used (hereinafter known as "Committee"), shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required. The practitioner with respect to whom an investigation has been requested shall have an opportunity to meet with the Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the practitioner shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Committee and included with its report to the Executive Committee. If a subcommittee or Investigating Committee was used, the Executive Committee may accept, modify, or reject the recommendation it receives from that Committee.

(c) The preceding shall not prevent the Board or Hospital administration from informally reviewing or investigating a practitioner under separate Board or Administrative procedures.

At any time during the investigation, the Executive Committee, with the approval of the President, may suspend all or any part of the clinical privileges of the person being informally reviewed and/or investigated. This suspension shall be deemed to be administrative for the protection of Hospital patients and should not last for longer than thirty (30) days pending the outcome of the investigation. It shall remain in effect during the investigation only, shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation shall be completed within thirty (30) days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.

Section 5. Focused Review and Monitoring. The Executive Committee may impose a requirement that a practitioner's clinical practice activities or records be concurrently monitored. Focused professional practice evaluation and monitoring is for the purpose of gathering information and does not constitute corrective action or commencement of an investigation. Consequently, it does not trigger hearing and appeal rights under these Bylaws.

Section 6. Procedure Following Conclusion of Informal Review or Investigation.

(a) In acting after the investigation, the Executive Committee may (i) dismiss the charges, (ii) issue a written warning, (iii) issue a letter of reprimand, (iv) impose terms of probation, (v) impose requirements of observation or concurrent monitoring, (vi) recommend reduction of clinical privileges, (vii) recommend temporary suspension of clinical privileges, or (viii) recommend revocation of staff appointment or reassignment to a lower category of staff.

(b) Any recommendation by the Executive Committee for reduction of clinical privileges, for suspension of clinical privileges for a term of twenty-eight (28) days or more after the Executive Committee acts, or for revocation or reduction of staff appointment shall entitle the affected practitioner to the procedural rights provided in Article VIII. Such a recommendation shall be forwarded to the

President who shall promptly notify the affected practitioner by certified mail, return receipt requested. The President shall then hold the recommendation until after the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article VIII. At the time the practitioner has been deemed to have waived his right to a hearing, the recommendation shall be forwarded, together with all supporting documentation, to the Board. The chairman of the Executive Committee or his designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

(c) If the action of the Executive Committee is less severe than reduction of clinical privileges, or suspension of clinical privileges for a term of twenty-eight (28) days or more, or revocation or reduction of staff appointment, the action shall take effect immediately without action of the Board and without the right of appeal. A report of the action taken and reasons therefor shall be made to the Board through the President and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee and such action would reduce clinical privileges, suspend clinical privileges for twenty-eight (28) days or more, or revoke or reduce staff appointment, it shall notify the practitioner through the President and shall take no final action thereon until the practitioner has exercised or has been deemed to have waived the procedural rights provided in Article VIII.

PART B: SUMMARY AND PRECAUTIONARY SUSPENSIONS OF CLINICAL PRIVILEGES

Section 1. Grounds for Summary Suspension.

(a) The Chief of Staff, the chairman of a clinical department, the President or, in his absence, his designee, or the Chairman of the Board shall each have the authority to suspend summarily all or any portion of the clinical privileges of a Medical Staff appointee for a period not exceeding fourteen (14) days pending an investigation to determine whether to proceed with corrective action, whenever such action must be taken immediately in the best interest of patient care or safety in the Hospital, or for the continued effective operation of the Hospital. Such suspension shall not imply final finding of responsibility for the situation that caused the suspension. Within fourteen (14) days following the imposition of summary action, the Executive Committee shall, on the basis of its preliminary investigation, determine whether summary action should be lifted or modified (whether or not corrective action goes forward) or continued (during any subsequent investigation and proceeding).

(b) Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President or, in his absence, his designee, or the Chief of Staff and shall remain in effect up to fourteen (14) days unless or until modified by the Executive Committee.

Section 2. Credentials or Executive Committee Procedure. The person who exercises his authority under Section 1 of this Part, to suspend summarily a person appointed to the Medical Staff, shall immediately report his action to the Chief of Staff. At that point, the Executive Committee shall investigate the matter and take such further action as is required in the manner specified under this Article. Summary suspension lasting fifteen (15) days or longer shall entitle the practitioner to the procedures specified in Article VIII.

Section 3. Precautionary Suspensions. The Chief of Staff, the chairman of a clinical department, the President or, in his absence, his designee, or the Chairman of the Board shall each have the authority to institute a precautionary suspension. A precautionary suspension may be used when there is a potential issue regarding patient safety, but no investigation or review has taken place. A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President, or in his absence, his designee, or the Chief of Staff and shall remain in effect until a summary suspension or other corrective action is taken. A precautionary suspension does not constitute punitive or corrective action and no procedures under Section VIII of these Bylaws shall apply.

Section 4. Care of Suspended Individual's Patients. Immediately upon the imposition of a summary or a precautionary suspension, the appropriate department chairman or, in his absence, the Chief of Staff shall assign to another person appointed to the Medical Staff responsibility for care of the suspended practitioner's patients still in the Hospital at the time of such suspension until such time as they are discharged. It shall be the duty of the Chief of Staff and the department chairman to cooperate with the President in enforcing all suspensions.

Section 5. Medical Staff Member Obligations. In the event of a summary or precautionary suspension, a practitioner shall be relieved of all Medical Staff duties and obligations, including but not limited to Medical Staff, departmental and Committee meeting attendance and general Medical Staff voting obligations, while such summary or precautionary suspension is in effect.

PART C: OTHER ACTIONS

Section 1. Action by State Licensing Agency. Action by the appropriate state licensing agency revoking or suspending a practitioner's professional license shall result in automatic relinquishment of all Hospital clinical privileges as of that date.

Section 2. Failure to Attend Meetings or Satisfy Continuing Education Requirements.

(a) Failure to attend meetings as required in these Bylaws may result in refusal of reappointment of the practitioner concerned. Failure to complete mandated continuing education requirements shall be considered a voluntary relinquishment of Medical Staff appointment. Such failures shall be documented and specifically considered by the Executive Committee when making its recommendation for reappointment and by the Board when making its final decision.

(b) Any practitioner whose reappointment has been refused for these reasons shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall not be conducted under the procedural rules provided in these Bylaws.

(c) If reappointment is refused by the Board, the practitioner shall be eligible to reapply for staff appointment and the application shall be processed in the same manner as if it were an initial application.

PART D: PROCEDURE FOR LEAVE OF ABSENCE

Practitioners appointed to the Medical Staff may, for good cause, be granted leave of absence by the Board for a definitely stated period of time. Requests for leaves of absence shall be made to the chairman of the department in which the practitioner applying for leave has his primary clinical privileges and shall state the beginning and ending dates of the requested leave.

The department chairman shall transmit the request together with his recommendation to the Executive Committee, which shall make a report and a recommendation for action by the Board. The practitioner on leave of absence must request reinstatement in writing before the Medical Executive Committee will consider the matter.

PART E: HEALTH ASSESSMENT

The Executive Committee may require any applicant or member to undergo a health assessment by a practitioner or at a facility selected by the Medical Executive Committee, at the expense of the Hospital. The health assessment shall result in a report of findings directly to the Executive Committee or its designee, for the purpose of determining the practitioner's ability to perform all of the essential functions required for exercise of professional responsibilities without posing a threat to patients. The failure of an applicant or member to obtain such an examination within a reasonable time after being directed to do so in writing by the Executive Committee shall constitute a voluntary relinquishment of all privileges currently held, and the withdrawal of all applications for privileges then pending, until such time as the Executive Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

PART F: RESERVED AUTHORITY

Notwithstanding any other provision of these Bylaws, the Board of Directors reserves the right to initiate or take action or take over any application, investigation, or corrective action proceeding when, after reviewing the matter with the Medical Executive Committee: (i) the Medical Executive Committee requests it to do so, or (ii) the Board determines that the Medical Executive Committee is unable or unwilling to act in a particular situation, or (iii) the matter involves JEMH policy or legal compliance rather than competence or professional conduct potentially adversely affecting patient welfare. When acting under this provision, the Board of Directors shall follow procedures and afford practitioners procedural rights similar to those afforded under these Bylaws.

ARTICLE VIII
HEARING AND APPEAL PROCEDURES

PART A: INITIATION OF HEARING

Section 1. Grounds for Hearing. Except as limited elsewhere in these Bylaws, a member or applicant shall be entitled to a hearing upon proper request whenever the Executive Committee makes a recommendation which, if adopted by the Board, would result in:

(a) Denial of requested Medical Staff membership or clinical privileges, on initial application or on application for reappointment or renewal;

(b) Denial of requested increase in clinical privileges or advancement in Medical Staff category (but not a denial of a request to move from Active Staff to another category);

(c) Involuntary suspension or expulsion from the Medical Staff;

(d) Involuntary limitation, reduction, suspension, or termination of clinical privileges lasting fifteen (15) days or longer, except for investigatory suspensions undertaken pursuant to Article VII, Section 2;

or the Board takes such action not based on prior adverse recommendation by the Executive Committee. No other action or recommendation will entitle the affected practitioner to a hearing under these Bylaws.

Section 2. Certain Unappealable Actions. Neither voluntary nor automatic relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirement, nor the imposition of a requirement for retraining, additional training, or continuing education, nor the requirement that a practitioner submit to a health assessment no matter whether imposed by the Executive Committee or the Board, shall constitute grounds for a hearing but shall take effect without hearing or appeal.

Section 3. Request for Hearing.

(a) **Notice of Decision**. In all cases in which the Executive Committee or the Board has taken action or made a recommendation constituting grounds for hearing, a written copy of the recommendation or written description of the action taken together with a statement of the grounds on which such recommendation or action is based shall be furnished to the President. The President will promptly notify the affected practitioner in writing of the action taken and furnish a copy of the recommendation or action taken and the grounds as a part of such notice. The President will furnish the practitioner with a summary of his hearing and appeal rights under the Bylaws (or provide the practitioner with a copy of the relevant portions of the Bylaws) and advise the practitioner in the notice of his right to request a hearing under these Bylaws.

(b) **Request for Hearing**. The affected practitioner will have thirty (30) days following the date of receipt of such notice within which to request a hearing before the Hearing Committee. The request for hearing must be by written notice to the President. In addition to requesting a hearing, such notice must respond point by point to each finding or ground relied upon by the Executive Committee in support of its action or recommendation. The response must clearly indicate in what respect, from the affected practitioner's point of view, each finding or ground of the Executive Committee and the final action or recommendation itself, is in error. No right to discovery applies, but the affected practitioner may request copies of documents relied upon by the Medical Staff or Hospital decision-maker in making the determination at issue. In the event the practitioner does not request a hearing within the time and in the manner prescribed, or in the event the notice is incomplete, and the practitioner does not furnish a complete notice within fourteen (14) days after the President points out the incompleteness, he will be deemed to have accepted the action involved, and it will thereupon become effective immediately.

Section 4. Hearing Committee.

(a) **Composition**. Within ten (10) days after receipt of a request for hearing, or as soon thereafter as reasonably possible, the President, after consultation with the Chief of Staff, will appoint a Hearing Committee and provide each member of the Hearing Committee with copies of the action or recommendation, the notice to the affected practitioner, and the practitioner's request for hearing. The Committee shall be formed under the following guidelines:

(1) The Committee will be composed of not fewer than three (3) practitioners, a majority of whom must be physicians, and none of whom should be in

direct economic competition with the affected practitioner as that term is defined by the Hospital. The Committee should, to the extent possible, be comprised of practitioners with privileges at the Hospital, but this guideline shall not control when its application would result in insufficient committee members, or would require appointment to the Committee of a practitioner who has initiated the complaint.

(2) By mutual written agreement between the practitioner requesting the hearing and the President, the composition of the Committee may be varied from the requirement of the preceding sentence, but the parties will each be deemed to have waived any objection to the variation to which he or it has agreed, and the practitioner shall be deemed to have consented to any time delay attributable to such variance.

(3) When the practitioner requesting the hearing is a non-physician practitioner, reasonable efforts will be made for at least one (1) member of the Hearing Committee to be a non-physician, preferably but not necessarily of the same profession as the affected practitioner. A non-physician practitioner who is not affiliated with the Hospital may be appointed to fill this position, if necessary.

(4) No person will be disqualified from serving on the Hearing Committee because of prior knowledge regarding the facts of the case.

(5) One of the members of the Hearing Committee will, at the time of appointment, be designated chairman of the Committee by the President, and will be provided with a list of witnesses who are at that time expected to testify at the hearing in support of the action or recommendation.

(6) If the hearing is based on action by the Board rather than action by the Executive Committee, the Hearing Committee may include a lay member of the Board or another non-practitioner.

(b) **Hearing Officer**. The President may, after consultation with the Chief of Staff, appoint a Hearing Officer as fact finder in lieu of the Hearing Committee described in this Article VIII. When so appointed, a Hearing Officer shall have the same authority and responsibilities as a Hearing Committee, and shall follow, insofar as practical, the same procedures. Such Hearing Officer is to be distinguished from the Presiding Officer appointed under subsection Part B, Section 2 of this Article VIII to assist a Hearing Committee.

(c) **Authority of Hearing Committee**. The Hearing Committee (through its Chairman or Presiding Officer) shall have authority to:

(1) Establish the time, place, manner, and procedure for conducting the hearing, consistent with these Bylaws;

(2) Hold a preliminary meeting with the parties for the purpose of clarifying issues, establishing procedures, or otherwise aiding the Committee;

(3) Rule on the admissibility of the evidence, and determine the weight to be accorded to evidence which is admitted;

(4) Request other members of the Medical Staff, other clinical practitioners with privileges at the Hospital, or outside experts to examine questions within their respective specialties or knowledge where a dispute exists between the position of the affected practitioner and the Executive Committee, and report to the Hearing Committee their opinions and the basis for those opinions;

(5) Conduct a hearing, consider and receive evidence, and deliberate and reach a determination in the form of a final recommendation;

(6) Direct the attendance and participation of witnesses, and the submission and introduction of documentary evidence, whether or not referred by the Executive Committee or the affected practitioner;

(7) Take such other actions as will facilitate its business; and

(8) Establish time limits for the conduct of the hearing and divide time between the parties equally.

(d) **Decision of Committee**. Upon reaching a decision, the Committee must reduce it to writing setting forth the recommendation or action and the grounds on which it is based. Only committee members who have attended all parts of the hearing will be entitled to participate in the deliberations or vote of the Committee. A quorum consists of not less than one-half (1/2) of the committee members. There may be no voting by proxy.

Section 5. List of Witnesses. If either party, by notice, requests a list of witnesses, then each party within ten (10) days of such request shall furnish to the other a written list of the names and addresses of the individuals so far as is then reasonably known who will give testimony or evidence in support of that party at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may, in the discretion of the Hearing Officer, be supplemented at any time during the course of the hearing.

Section 6. Clarification of Issues.

(a) **Outline of Case**. At any time during the proceedings, the Hearing Committee may require the affected practitioner and the Executive Committee to each submit an outline to the President for transmittal to the Committee and to the other party setting forth so far as is then reasonably known:

(1) Issues which each party proposes to raise at the hearing;

(2) Witnesses whom each party proposes to call at the hearing and the subject or subjects on which such witnesses will testify;

(3) A description of written or documentary evidence which each party anticipates introducing as evidence at the hearing;

(4) A short summary of what the party expects to demonstrate at the hearing in support of its position; and

(5) The specific result or results requested from the Committee.

(b) **Notice of Hearing**. The Committee shall schedule the hearing. The Executive Committee (or the Board if the Board's decision prompted the hearing) and the affected practitioner shall be given written notice stating the place, time and date of the hearing not less than thirty (30) days prior to the scheduled date thereof, together with a written list of the witnesses which the other party proposes to call at such hearing.

Section 7. Failure to Appear. Failure, without good cause, of the person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending which shall then become final and effective immediately.

Section 8. Postponements and Extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone but shall be permitted only by the Hearing Committee or its chairman or presiding officer acting upon its behalf on a showing of good cause.

Section 9. Deliberations and Recommendations of the Hearing Committee. Within twenty (20) days after final adjournment of the hearing, the Hearing Committee shall conduct its deliberations outside the presence of any other person except the Hearing Officer and shall render a recommendation, accompanied by a report which shall contain a concise statement of the reasons justifying the recommendation made, and shall deliver such report to the President.

Section 10. Disposition of Hearing Committee Report. Upon its receipt, the President shall send a copy of the report and recommendation by certified mail, return receipt requested, to the person who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, the report of the Hearing Committee shall be delivered by the President to the applicable committee for whatever modification, if any, it may wish to make to its original recommendation. If it has been conducted by reason of an action of the Board or its committee, the report of the Hearing Committee shall be delivered to the Board or that committee.

PART B: HEARING PROCEDURE

Section 1. Representation. The person requesting the hearing shall be entitled to be represented at the hearing by an attorney or a physician of his choice to examine witnesses and present his case. He shall inform the President in writing of the name of that person at least ten (10) days prior to the date of the hearing. The Executive Committee or the President acting for the Board, whichever is appropriate, shall appoint a representative, who may be an attorney, to present its recommendations and to examine witnesses.

Section 2. The Presiding Officer. The President, after consultation with the Chief of Staff and the Committee Chairman, may appoint a Presiding Officer, who shall be an attorney-at-law, to preside at the hearing. He must not act as a prosecuting officer or as an advocate for the Board or the Executive Committee. He may participate in the private deliberations of the Hearing Committee and be a legal advisor to it, but he shall not be entitled to vote on its recommendations. He may thereafter continue to advise the Board on the matter.

The Presiding Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing, and that no intimidation is permitted. He shall determine the order of procedure throughout the hearing and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of

procedure and to the admissibility of evidence, upon which he may be advised by legal counsel to the Hospital. In all instances, he shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Committee in formulating its recommendations. It is understood that the Presiding Officer is acting at all times to see that all relevant information is made available to the Hearing Committee for its deliberations and recommendations to the Board.

Section 3. Record of Hearing. The Hearing Committee shall maintain a record of the hearing through a reporter who will be present to make a record of the hearing or through a recording of the proceedings. The cost of such reporter shall be borne by the Hospital. The Hearing Committee may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

Section 4. Rights of Both Sides. At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the person requesting the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination. Both sides shall have the right, if they so request at the conclusion of the hearing, to submit a memorandum of points and authorities within five (5) days following conclusion of the hearing.

Section 5. Admissibility of Evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the Presiding Officer, 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. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Committee may request such a memorandum to be filed following the close of the hearing. The Hearing Committee may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems appropriate.

Section 6. Official Notice. The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 7. Parties. The parties to the hearing shall be the affected practitioner and the Medical Executive Committee. The Medical Executive Committee may designate one or more of its members to represent its position before the Judicial Review Committee or may designate an individual active in prior consideration to represent its position.

Section 8. Witnesses. The Committee may order that witnesses be sequestered. Testimony of character witnesses and patients who can testify generally on behalf of the affected practitioner will not be considered relevant to the proceedings.

Section 9. Non-Public Meeting. Proceedings will be conducted in private, before the parties and their representatives, the Committee and the court reporter.

Section 10. Basis of Decision. The decision of the Hearing Committee shall be based on the evidence produced at the hearing.

Section 11. Burden of Proof. At any hearing involving as grounds for hearing the denial of requested membership or privileges or the denial of reappointment or renewed privileges, the burden shall be upon the applicant, member, or other privileged practitioner to establish his entitlement to the requested membership or privileges. The Committee shall rule against the practitioner unless it determines that the practitioner has proved that the recommendation of the Medical Executive Committee was arbitrary, unreasonable, or not supported by any evidence. At any hearing growing out of an action or recommendation by the Medical Executive Committee dealing with corrective action, the burden shall be upon the Medical Executive Committee to support its action and recommendation. Thereafter, the burden shall shift to the practitioner who requested the hearing to come forward with evidence in support of his position. The Committee shall rule against a practitioner unless it determines that the action or recommendation of the Medical Executive Committee was arbitrary, unreasonable, or not supported by any evidence.

Section 12. Adjournment and Conclusion. The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Section 13. Legally Protected Information. To the extent that evidence at hearing and the information to be provided by the Hospital to the practitioner and his or her legal counsel or experts includes individually identifiable health information protected under HIPAA or the regulations issued thereunder, the Hospital President and Hearing Panel or Officer may condition the furnishing of such information to the practitioner and the practitioner's legal counsel upon the receipt of signed confidentiality agreements agreeing not to use or disclose such protected information except in connection with the conduct of the peer review proceedings and further agreeing to return all copies at the conclusion of the hearing and appeal process.

PART C: APPEAL

Section 1. Time for Appeal. Within fifteen (15) days after the affected practitioner is notified of either (1) a final recommendation adverse to him made by the Executive Committee after a hearing, if he has requested one, or (2) an adverse recommendation from a Hearing Committee directly to the Board, he may request an appellate review. The request shall be in writing and shall be delivered to the President, either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within fifteen (15) days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved, and it shall thereupon become final and immediately effective.

Section 2. Grounds for Appeal. The grounds for appeal from an adverse recommendation shall be that:

(a) there was substantial failure on the part of the Executive Committee or Hearing Committee to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or

(b) the recommendation was made arbitrarily, capriciously, or with prejudice; or

(c) the recommendation of the Executive Committee or Hearing Committee was not supported by the evidence.

Section 3. Time, Place and Notice. Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected practitioner to be given notice of the time, place, and date of the appellate review. The date of the appellate review shall be not less than twenty (20) days nor more than forty (40) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

Section 4. Nature of Appellate Review. The Chairman of the Board shall appoint a Review Panel composed of not less than three (3) persons, either its own members, reputable persons outside the Hospital, or a combination of the two, to consider the record upon which the recommendation before it was made. The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Committee proceedings. Each party shall have the right to present a written statement in support of his position on appeal and, in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

Section 5. Final Decision of the Board. Within thirty (30) days after the conclusion of the proceedings before the Review Panel, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Executive Committee in person or by certified mail.

Section 6. Further Review. Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

Section 7. Right to One Appeal Only. No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Executive Committee, the Credentials Committee, or Hearing Committee, or a combination of acts of such bodies. However, nothing in these Bylaws shall restrict the right of the applicant to apply for appointment to the Medical Staff or restrict the right of an appointee to apply for reappointment or an increase in clinical privileges after the expiration of two (2) years from the date of such Board decision unless the Board provides otherwise in its written decision.

ARTICLE IX
RULES AND REGULATIONS OF THE MEDICAL STAFF

The Medical Staff, with the approval of the Board, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in

these Bylaws. Rules and Regulations shall set standards of practice that are to be required of each physician, dentist, and non-physician in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

Particular Rules and Regulations may be amended, repealed or added by vote of the Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions, or repeals are posted in a conspicuous place in the Medical Staff lounge and made available to all members of the Executive Committee fourteen (14) days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff be brought to the attention of the Executive Committee before the change is voted upon. Changes in the Rules and Regulations shall become effective only when approved by the Board.

Rules and Regulations and appendices to the Bylaws may also be amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose, provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board.

ARTICLE X
SUPERVISION

The assignment of responsibility to proctors, monitors, department chairmen or their designees, committee chairmen or their designees, or officers of the Medical Staff, for observation or supervision of practitioners during the provisional period, during probation, during temporary appointment, or during other periods of evaluation and supervision is for the limited purpose of observation and peer review only, and no direct duty, responsibility, or relationship to or on behalf of individual patients is thereby implied or formed.

ARTICLE XI
AMENDMENTS

All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the Executive Committee. The Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. They shall be voted upon at that meeting, provided that they have been posted in a conspicuous place in the Medical Staff lounge at least fourteen (14) days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.

The Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. The Executive Committee shall have the power to adopt all amendments to the Bylaws appendices. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. After adoption, such amendments shall, as soon as practicable, be posted in a conspicuous place in the Medical Staff lounge for fourteen (14) days and sent to the President.

ARTICLE XII
ADOPTION

These Bylaws are adopted and made effective _____, 2021 superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each and every appointee to the Medical Staff shall be taken under and pursuant to the requirements of these Bylaws.

The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect pursuant to these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

APPROVED by the Medical Staff on _____, 2021.

_____
Tri Tran, MD, Chief of Staff

ADOPTED by the Board on _____, 2021.

_____
Dan Kinney, Chairman Board of Directors

APPENDIX A

COMMITTEES

BYLAWS COMMITTEE

The Bylaws Committee shall consist of not fewer than three (3) members of the Medical Staff. Requests for amendments should be referred to the Committee for consideration and report to the Executive Committee. At least once every three (3) years, the Committee should complete a comprehensive review of the Bylaws and Rules and Regulations and make report to the Executive Committee.

CANCER CARE COMMITTEE

The Cancer Care Committee shall be responsible for planning, initiating and assessing all cancer-related activities in the Hospital in order to provide a supportive care system for all patients with cancer.

Composition. The Committee shall consist of members of the Medical Staff to include cancer physician liaison, general surgery, medical oncology, pathology, radiation oncology, Radiology and other disciplines representative of the major types of cancers treated at the Hospital. Representatives from administration, nursing, social services, tumor registry, quality management, radiation oncology, pharmacy, dietary and rehabilitation therapy shall be nonvoting members of this Committee.

Responsibilities.

1. Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer and provides oversight of Cancer Care programs.

2. Promotes a coordinated, multidisciplinary approach to patient management.

3. Ensures that educational and consultative cancer conferences cover all major sites and related issues.

4. Ensures that an active supportive care system is in place for patients, families, and staff.

5. Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.

6. Promotes clinical research.

7. Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting.

8. Performs quality control of registry data.

9. Encourages data usage and regular reporting.

10. Ensures content of the annual report meets requirements.

11. Publishes the annual report by November 1 of the following year.

12. Upholds medical ethical standards.

13. Provides opportunities for continuing medical education in the area of Cancer Care.

Meetings, Reports and Recommendations. The Cancer Care Committee shall meet at least quarterly, shall maintain a record of its proceedings and activities, shall report to the Executive Committee and shall publish and distribute an annual report.

COMPREHENSIVE REVIEW COMMITTEE

Composition. The Comprehensive Review Committee shall consist of a Chairman, members of the medical staff to include a chairman and representatives from the surgery department, primary care department, Anesthesiology, Emergency Services, Pathology, and Radiology, Hospital Medicine, and infectious disease. The committee chairman may invite nonvoting representatives of clinical and ancillary support services.

Duties. The Comprehensive Review Committee shall:

(a) Direct, coordinate, and follow up the work of the departmental review subcommittees and receive reports in writing from the aforementioned subcommittees regarding clinical effectiveness/quality management activities.

(b) Conduct quality improvement activities in accordance with the Hospital's quality improvement plan and review and evaluate the Hospital's quality improvement plan. The quality improvement plan shall be structured and implemented to include systematic monitoring and evaluation of the quality of the care of patients served by the Hospital and the clinical performance of all individuals with clinical privileges. Problems identified through the quality improvement process involving individual practitioners will be referred to the department or Executive Committee as appropriate.

(c) Submit to the Executive Committee and the President at least quarterly, through its chairman, a written report outlining the work done.

(d) Make recommendations to the Executive Committee regarding the establishment, maintenance, and improvement of professional standards within the Hospital.

(e) Meet at least six (6) times annually and keep minutes of all such meetings.

(f) Supervise the maintenance of medical records to assure the required standards of completeness and timeliness.

(g) Cause the review of the agreement and disagreement between the preoperative, postoperative, and pathological diagnosis and as to whether the surgical procedures undertaken in the Hospital are justified.

(h) Review the appropriateness of blood transfusions.

(i) Perform the Tissue Review function.

(j) Function as the Utilization Management Committee and conduct utilization review in accordance with the Hospital's Utilization Management Plan. This shall include at a minimum:

(1) Evaluate the Utilization Management Plan to assure that it meets the current requirements of law and regulations. The Plan must include provision for: review of the appropriateness and medical necessity of admissions, continued Hospital stays, and supportive services, discharge planning, and data collection and reporting.

Cause review of apparently overlong Hospital stays, unnecessary Hospital admissions, undue delay in the use of Hospital facilities, delay in requesting or obtaining consultation, and all other matters having to do with efficient, good patient care and the proper utilization of the Hospital facilities.

(2) Monitor the performance of individual members and practitioners under guidelines established by third party payors.

(k) Act as the liaison between the Hospital and any CMS quality improvement organization.

(l) Review findings on problems encountered during record review, including diagnosis and coding.

(m) Review and evaluate the Patient Safety activities of the Hospital.

(n) Identify educational needs of the Medical Staff by accepting referrals and suggestions for programs from departments and by reviewing areas for performance improvement.

(o) Approve and evaluate CME programs.

(p) Investigate, control, and prevent infections within the Hospital. Review existing practices including isolation/precaution procedures, procedures relating to infection control, and the use of antibiotics. Conduct ongoing surveillance of the infection rate and recommend appropriate action when significant deviations or alterations occur.

(q) Review the infection control policies of the Hospital.

(r) Institute appropriate measures or investigations necessary to avoid or control the spread of infection at the Hospital.

In the performance of the above duties, the Committee shall have access to all records pertaining to any aspect of clinical practice. The Chairman shall appoint a subcommittee composed of members of the Committee who shall act on behalf of the Committee in all matters involving the medical management of a case or the actions of an individual practitioner. The Chairman shall serve as a member of the Executive Committee.

Meetings, Reports, and Recommendations. The Comprehensive Review Committee shall meet at least six times annually. Copies of all minutes, reports, and recommendations shall be transmitted to the Executive Committee.

CREDENTIALS COMMITTEE

Composition. The Credentials Committee shall consist of the Chief of Staff, Vice Chief of Staff, immediate past Chief of Staff, six (6) additional physician members, and the CEO or his designee(s).The Vice Chief of Staff shall act as chairman.

Duties. The duties of the Credentials Committee shall be:

(a) To receive recommendations from the Department Chairman/Department regarding Medical Staff appointments, reappointments, change in privileges or change in membership category and make recommendations to the Executive Committee.

(b) To review all references and request additional references that it may deem necessary.

(c) To verify as it deems necessary all information submitted by the applicant and satisfy itself that sufficient confirmed information is present that will allow the Executive Committee to make a fully informed recommendation regarding the appointment of the candidate to the Medical Staff.

(d) To determine whether the practitioner, during appointment to the Provisional Staff, has fulfilled all requirements for reassignment to his requested category of staff.

(e) Periodically review utilization of Allied Health Practitioners in the Hospital and study and recommend to the President the need for Allied Health Practitioners and how they should be reviewed and supervised.

(f) In consultation with the appropriate department chairmen, develop criteria and conditions for the registration of AHPs at the Hospital.

(g) In consultation with the appropriate department chairmen, review applications for registration by individual AHPs and make recommendations to the Executive Committee.

(h) Assure that all AHPs are adequately supervised and evaluated and that the results of their work are included in quality assessment activities of the Medical Staff or other evaluations, as appropriate.

The committee shall be assisted in its duties by the Hospital administration.

Meetings, Reports, and Recommendations. The Credentials Committee shall meet preferably on a monthly basis, but no less than six (6) times per year; shall maintain a permanent record of its proceedings and actions; and shall report to the Executive Committee.

CREDENTIALS/QUALITY/SAFETY COMMITTEE

Composition. The Credentials/Quality/Safety Committee (CQSC) shall consist of three (3) members of the Board of Directors appointed by the Chairman, the Vice Chief of Staff, one (1) other physician, and the President or his designee.

Duties. The CQSC shall:

(a) Receive and review reports regarding clinical effectiveness/quality management activities.

(b) Receive and review reports regarding risk management activities.

(c) Receive and review the approval/disapproval of the Medical Staff/Executive Committee recommendations for staff appointment and privileges. CQSC has the appropriate membership to conduct expedited review (as set forth in Article VI, Part G, Section 2) and has been delegated by the Board of Directors to grant appointment, reappointment, or renewal or modification of clinical privileges. A positive decision by the Committee results in the status and/or privilege requested. If a decision is adverse to an applicant, the matter may be referred back to the Medical Staff Executive Committee for further evaluation. CQSC will forward to the Board of Directors for final ratification when the following has occurred:

(1) A final recommendation of the Medical Staff Executive Committee that is adverse or with limitation;

(2) A current challenge or a previous successful challenge to licensure or registration;

(3) Involuntary termination of medical staff membership at another organization;

(4) Involuntary limitation, reduction, denial, or loss of clinical privileges.

(5) There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

(d) It shall consider and make recommendations regarding any disagreements between a recommendation of the Medical Staff and a recommendation or decision by the Board of Directors regarding an applicant or staff member, but

need not do so if a Hearing Committee has been formed to hear a matter and make a recommendation to the Board under Article VIII of these Bylaws.

Meetings, Reports and Recommendations. The CQSC shall meet preferably monthly but no less than six (6) times per year. The Committee forwards its recommendations to the Board of Directors.

EMERGENCY/TRAUMA COMMITTEE

Composition. The Emergency/Trauma Committee shall be composed of a chairman, the Emergency physicians, Trauma surgeon(s), three (3) other members of the medical staff, the Director of Emergency Services and a representative of Administration.

Duties. The Emergency Committee shall:

(a) Establish standards, policies and protocols based on evidence-based information. These policies and procedures should be reviewed at least annually.

(b) Conduct performance improvement activities and recommend follow up as indicated.

(c) Assess education needs and develop programs for the Emergency and/or Trauma care teams.

(d) Conduct case review, implement corrective action and initiate Peer Review as identified through the review process.

Meetings, Reports, and Recommendations. The Emergency Department Committee shall meet at least quarterly and report to the Executive Committee.

ETHICS COMMITTEE

Composition. The Ethics Committee shall consist of three (3) physicians

Duties. The Ethics Committee reviews ethical issues regarding patient care and makes recommendations for resolution.

Meetings, Reports and Recommendations. The Committee shall meet as needed and shall report its actions to the Executive Committee.

JOINT CONFERENCE COMMITTEE

Composition. The Joint Conference Committee shall consist of the Chairman of the MJE Board of Directors, two other members of the Board of Directors appointed by the Chairman, the Chief of Staff, the Vice-Chief of Staff, two other physicians appointed by the Chief of Staff and

the President or his designee. The Chairman of the Board shall serve as Chairman of the Joint Conference Committee.

Duties. The Joint Conference Committee shall be a forum for discussion of matters of hospital policy and practice especially those pertaining to patient care, and shall provide medico-administrative liaison with the Board and the President. The Committee shall perform such additional duties as may be required by law or regulation or given it by the Board and shall also consider and make recommendations regarding any disagreements between a recommendation of the Medical Staff and a recommendation or decision of the Board of Directors regarding an applicant or staff member.

Meetings, Reports, and Recommendations. The Joint Conference Committee shall meet as appropriate and shall transmit written reports of its activities to the Board, the Executive Committee of the Medical Staff and the President.

NOMINATING COMMITTEE

Composition. The Nominating Committee shall consist of the three most recent past Chiefs of Staff who are still members of the Active Medical Staff and three other members of the Active Staff. One member shall be designated by the current Chief of Staff as Chairman. The VP of Medical Affairs shall act as recorder.

Duties. The Nominating Committee shall nominate one candidate for each of the following positions if they are vacant or will become vacant: (i) an officer of the Medical Staff, (ii) chairman of the Departments, (iii) such other officers for any Department as are desired by the Department, and (iv) additional members from the departments for the Executive Committee.

Meetings, Reports and Recommendations. The Nominating Committee shall meet as required to make nominations for vacant positions. The current Chief of Staff shall be responsible for calling meetings of the Committee. The Nominating Committee's nominations shall be reported to the Executive Committee and shall also be published for the members of the Active Staff to review.

PEER REVIEW COMMITTEE

Composition. The Peer Review Committee shall be a subcommittee of the Credentials Committee with composition being the Credentials Committee in its entirety. The Vice Chief of Staff shall act as chairman.

Duties. The duties of the Peer Review Committee shall be:

(a) To review medical records of cases forwarded to the Committee for review;

(b) To gather information, evaluate and render recommendations on cases; and,

(c) To communicate such recommendations to the physicians under review.

The Committee shall be assisted in its duties by the Hospital Administration.

Meetings, Reports, and Recommendations. The Peer Review Committee shall meet as needed to review cases designated for review and shall maintain a permanent, privileged record of its proceedings and actions. The activities of the Committee are privileged under Iowa Code Section 147.135.

PHARMACY AND THERAPEUTICS COMMITTEE

Composition. The Committee shall consist of members of the Medical Staff to include a Chairman, a representative from infectious disease, at least one (1) representative from the Surgical Services Department and at least one (1) representative from the Primary Care Department. Representatives from administration, Nursing Service, Pharmacy, Administration, and Performance Improvement shall be nonvoting members of this Committee.

Duties. The Pharmacy and Therapeutics duties shall be to examine all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and minimize potential for harm. The Committee shall recommend to the Executive Committee the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, safety procedures, and all other matters relating to drugs, biologicals and devices in the Hospital. It shall also perform the following specific functions:

(a) Serve as advisory to the Medical Staff and the pharmacist on matters pertaining to the choice of available drugs.

(b) Approve therapeutic interchanges.

(c) Approve formulary drugs for use in the Hospital.

(d) Prevent duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Approve medication-use process policies (e.g., renal dosing/IV to PO).

(h) Review antibiotic usage and lead antibiotic stewardship initiatives in the Hospital.

(i) Approve drugs for which automatic stop orders are necessary.

(j) Review completed drug use evaluations and subsequent recommendations.

(k) Approve Diet Manual for nutritional services.

Meetings, Reports, and Recommendations. The P&T Committee shall meet at least every other month, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a report thereof to the Executive Committee and the President. When called for in the Hospital's Performance Improvement Plan, the Committee shall report directly to the Comprehensive Review Committee.

APPENDIX B

CONFLICT OF INTEREST GUIDELINES FOR COMMITTEES

These guidelines are adopted to address the process for addressing conflicts which arise involving Medical Staff committee responsibilities, in a manner reflecting ethical obligations and sound management practice.

Associate means a practitioner who is a partner, employee, or associate of the same group with which the Committee Member is associated.

Committee Member means a member of a Committee or Subcommittee of the Medical Staff.

Family Member means spouse, parents, grandparents, children (and their spouses), and grandchildren (and their spouses), and others living in a person's home.

When serving as a Committee Member, each person serves in an individual capacity, and not in a representative capacity as the agent of another person or entity. All decisions by Committee Members should be based on the individual's determination of what is in the best interest of the Medical Staff and the Hospital, exercising his best care and judgment in making that determination.

A Committee Member will be deemed to have a potential conflict of interest if he, or a member of his family, or an Associate, is the subject of a Committee's review obligations. Whenever a potential conflict of interest arises, the Committee Member should disclose it to the other members of the Committee. Any Committee Member who has a possible conflict of interest in any matter should not vote or use his personal influence on the matter, and he should not be counted in determining the quorum for a meeting at which the matter is discussed.

These guidelines do not prevent a Committee Member from briefly stating his position on a matter, nor from answering pertinent questions of other Committee members at the meeting since his knowledge may be of assistance.

The minutes of the Committee meeting should reflect that a disclosure was made, which Committee members were present for the discussion, the content of the discussion, the abstention from voting, and whether or not a quorum was present, considering any abstentions.

A Committee Member who fails to comply with these guidelines may be requested to resign from or be removed from serving on a Committee.