MEDICAL STAFF BYLAWS, RULES & REGULATIONS

Version 2016

METHODIST JENNIE EDMUNDSON
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, Provisional Staff, Courtesy Staff, and Consulting Staff, as applicable, consultation, teaching assignments, and minimum patient contact requirements. However, members of the Provisional Staff may not vote, hold office, or serve as chairmen or vice chairmen of committees.

Section 1. Duration. Appointment to the Provisional Staff shall be for twenty-four (24) months.

Section 2. Minimum Patient Contact Requirements. In order to permit observation and evaluation of practitioners, members of the Provisional Staff applying for Active Staff status shall admit or attend not fewer than two (2) patients per month or a total of twenty-four (24) patients per year at the Hospital during the provisional period. Members of the Provisional Staff applying for Courtesy or Associate Staff shall admit, co-admit, or attend not fewer than six (6) patients per year during the provisional period. Members of the Provisional Staff applying for Consulting Staff shall participate in the care of not fewer than six (6) patients per year to be automatically eligible for the Consulting Staff. This provision may be waived by the Executive Committee based on Medical Staff composition or other relevant factors.

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 for 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, Courtesy Staff, and Consulting Staff, as applicable, consultation, and teaching assignments. Members of the Active Staff must have first served not less than two (2) years on the Provisional or some other category of staff. All members of the 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 physicians and oral surgeons who are on the active medical staff of another hospital and who use the Hospital less frequently than members of the Active Staff (a yearly average of less than five patients admitted or attended per month). If this maximum admission or attendance rate is exceeded within any one Medical Staff year, the Executive Committee may require the practitioner to qualify for Active Staff status, which can include appointment to the Provisional Staff, or to relinquish his privileges altogether. Members of the Courtesy Staff shall not be entitled to vote, to hold office or to serve as chairman of departments or committees.

When necessary due to the number of physicians in a specialty, members of the Courtesy Staff shall be obligated to provide a reasonable amount of call coverage, on a shared basis with members of the Active Staff, Provisional Staff and Consulting Staff, as applicable.

Members of the Courtesy Staff (and members of the Provisional Staff applying for Courtesy or Associate Staff) shall admit, co-admit, attend or participate in the care of not fewer than six (6) patients per year.

PART D: CONSULTING STAFF

The Consulting Staff shall consist of practitioners who attend patients only in a consulting role at the request of the patient's Attending Physician and who do not regularly practice at the Hospital. Practitioners appointed to the Consulting Staff shall not be entitled to vote, admit or co-admit patients, hold office or to serve as chairmen of departments or committees.

When necessary due to the number of physicians in a specialty, members of the Consulting Staff who reside near enough to the Hospital to satisfy call requirements shall be obligated to provide a reasonable amount of call coverage, on a shared basis with members of the Active Staff, Provisional Staff and Courtesy Staff, as applicable.

PART E: 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. Members of the Associate Staff shall not be entitled to vote, hold office, or to serve as chairmen of departments or committees.

PART F: *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 G: 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. They are not eligible to hold office, or to serve as Department Chair, Section Chair, but may be a member of the Medical Executive Committee. Ambulatory Staff members are not subject to Focused Professional Practice Evaluation upon initial appointment, nor are they subject to Ongoing Professional Practice Evaluation.

PART H: MEDICAL STAFF CATEGORIES – GENERAL

Members of the Courtesy, Consulting 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, Consulting, and Associate Staffs are encouraged to attend the scientific portion of Medical Staff and department meetings.

PART I: 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 to be performed by Hospital personnel and reported back, 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 ordered by a reference practitioner.

PART J: 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;

(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 so during their term of office. 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 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) Keep accurate and complete minutes of all staff and Executive Committee meetings;

(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.

(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 mail and their votes returned to the Chief of Staff by mail. 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, 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 will constitute grounds for removal from a committee and will 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 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 to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care provided by members of the department.

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

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 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.

(c) 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 a written petition provided in advance to the Nominating Committee with at least twenty (20) signatures of department members.

(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, and to the Board at its next meeting following action by the Executive Committee.

(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) two (2) additional members from the Primary Care Services Department,

(d) two (2) additional members from the Surgical Services Department,

elected by such Departments, who shall serve for a term of two (2) years.

(e) the chairman of the Comprehensive Review Committee

(f) The medical directors or designee of:

Anesthesiology

Pathology

Radiology

Emergency Services

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 will maintain reports of all meetings, 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**. Provide or arrange for continuous, appropriate care for all patients under his or her care, and avoid inappropriate delegation of responsibility for treatment, follow-up treatment, diagnosis or other care.

(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 the Medical Staff shall be to the Provisional Staff as described in Article II, Part A. All initial clinical privileges shall be provisional for a period of 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 initial term 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.

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 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.

(f) The focused professional practice evaluation may include assessing whether an admission or procedure was medically appropriate, whether the level of care and medical decision-making provided were appropriate, whether medical record entries were complete, informative and legible, whether the practitioner's initial orders and use of diagnostic and ancillary services were appropriate, whether the patient's length of stay was appropriate, whether complications were anticipated, recognized promptly and dealt with appropriately, and whether the patient was discharged to an appropriate level of care. In addition, the practitioner may be assessed on basic medical knowledge, clinical judgment, communication skills, use of consultants, professionalism and nature of relationship with patients, families and staff.

(g) 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 distant sites shall be credentialed and privileged in accordance with these Bylaws. In cases in which the practitioner is credentialed at another hospital or facility, the Medical Staff may, at its discretion, review the current Medical Staff application from such facility; provided, however, that primary source verification of current license, relevant training or experience, current competence, and a National Practitioner Data Bank query are conducted. However, the applicant must, at minimum, sign authorizations and releases pertinent to Hospital 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 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 Medical Staff member 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.

(e) Reside in sufficient proximity to the Hospital (office and residence within thirty (30) minutes) 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.

(a) Any practitioner requesting an increase in clinical privileges will undergo a focused professional practice evaluation pursuant to criteria determined by the Credentials Committee.

(b) The focused professional practice evaluation may include assessing whether an admission or procedure was medically appropriate, whether the level of care and medical decision-making provided were appropriate, whether medical record entries were complete, informative and legible, whether the practitioner's initial orders and use of diagnostic and ancillary services were appropriate, whether the patient's length of stay was appropriate, whether complications were anticipated, recognized promptly and dealt with appropriately, and whether the patient was discharged to an appropriate level of care. In addition, the practitioner may be assessed on basic medical knowledge, clinical judgment, communication skills, use of consultants, professionalism and nature of relationship with patients, families and staff.

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.

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. A practitioner is not "under investigation" by the Medical Staff simply because the corrective action process 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 is not corrective action or 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 therefore 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 right 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, until the matter is resolved and the license restored.

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 decisions.

(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 leaves 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.

PART E: HEALTH ASSESSMENT

The Executive Committee may, without giving rise to hearing and appeals procedures under Article VIII, require any applicant or member to undergo, at the expense of the Hospital, a health assessment with reporting of findings directly back to a committee composed of the officers of the Medical Staff who shall report to the Executive Committee or its designee, for the purpose of determining practitioner's ability to perform all of the essential functions required for safe and effective exercise of professional responsibilities without posing a threat to patients. When the Executive Committee determines that there is a need for a health assessment, it shall require the applicant or member to submit within a stated period of time, a list of three practitioners for the Executive Committee's consideration. If none are acceptable to the Executive Committee, the applicant or member shall be required to submit a list of three additional practitioners for consideration, and so on, until the Executive Committee has accepted a practitioner. In the event the member or applicant fails to submit a list within the allotted time, the Executive Committee may select a practitioner and a facility, but in doing so the Executive Committee shall avoid selecting a practitioner who is or may be prejudiced in the case or selecting a practitioner who knows or is known by the member or applicant (unless the member or applicant consents). 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.

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

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. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital corporation, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out.

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 and advise the affected 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 or she 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 or partners or associates of the affected practitioner. 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 in any manner, but the practitioner requesting the hearing will 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 individual requesting a hearing. 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 lay members 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 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 with 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. Basis of Decision. The decision of the Hearing Committee shall be based on the evidence produced at the hearing.

Section 8. Burden of Proof.

(a) At any hearing resulting from an action or recommendation during corrective action proceedings, the spokesman for the Board or the Executive Committee will have the initial burden of producing evidence in support of the action or recommendation. At any hearing resulting from an action or recommendation during the original application or reappointment process, and at any hearing following corrective action proceedings once the spokesman has produced the evidence in support of the action or recommendation, the individual requesting the hearing will have the ultimate burden of producing evidence in his support.

(b) In all cases in which a hearing is conducted under this Article, after all the evidence has been submitted by both sides, the Hearing Committee shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation which prompted the hearing was arbitrary or capricious, not sustained by the evidence, or otherwise unfounded.

Section 9. 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 10. 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 February 17, 2016 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 January 19, 2016.

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Patrick Ahrens, MD, Chief of Staff

ADOPTED by the Board on February 17, 2016.

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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, appointed by the Chief of Staff with the concurrence of the Executive Committee. 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 and Vice Chairman who shall, with the concurrence of the Executive Committee, be designated by the Chief of Staff, Vice Chairman of each clinical department (to be selected by that department), a representative from Anesthesiology, Emergency Services, Pathology, and Radiology, Hospital Medicine, the President or his designee, and such representatives of clinical and ancillary support services as designated by the chairman.

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 KEPRO.

(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 and six (6) additional physician members appointed to that Committee by the Chief of Staff with the concurrence of the Executive Committee, 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 IMPROVEMENT COMMITTEE

Composition. The Credentials/Quality Improvement Committee (CQIC) 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 CQIC 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. CQIC 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. CQIC 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 CQIC 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 will be appointed by the Chief of Staff. It shall be composed of the Emergency physicians, Trauma surgeon(s), three (3) other members of the medical staff, the Director of Emergency Services and a representative of Administration. The Chairman shall be the Medical Director of Emergency Services.

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 in writing to the Comprehensive Review Committee and the Executive Committee.

INSTITUTIONAL REVIEW BOARD AND ETHICS COMMITTEE

Composition. The Chief of Staff shall appoint three (3) physicians to the Hospital Institutional Review Board (IRB) and Ethics Committee.

Duties. The IRB is responsible for protecting the rights, safety and welfare of human subjects participating in clinical trials of investigational drugs and devices and other research. The Ethics Committee reviews ethical issues regarding patient care and makes recommendations for resolution.

Meetings, Reports and Recommendations. The Committee shall meet as needed, but at least annually, 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 to be appointed by the current Chief of 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 and vice 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 Pharmacy and Therapeutics Committee shall consist of at least one (1) representative from Pulmonology/Infectious Disease, at least one (1) representative from the Internal Medicine or Family Practice Divisions, and at least one (1) representative from the Surgical Services Department, Nursing Service, Pharmacy, Administration, and Performance Improvement.

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.

PRIMARY CARE SERVICES COMMITTEE

Composition. The Primary Care Services Committee shall consist of the Chairman of the Primary Care Services Department, the Vice Chairman and any other officers of the Primary Care Services Department, additional representatives from the Primary Care Services Department as designated by the Chairman, a representative from the Radiology Division as designated by the Medical Director, the President or his designee, and such representatives of clinical and ancillary support services as designated by the Chairman. The Vice Chairman of the Department shall act as chairman of the committee.

Duties. The Primary Care Services Committee shall:

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

(b) Monitor and evaluate the quality and appropriateness of the care provided by members of the Department and select cases for presentation at Department meetings that will contribute to the continuing education of the members of the Department.

(c) Conduct performance improvement activities that relate to department services, including exercising responsibility and oversight over national quality indicators relating to primary care services.

(d) Review Mortality/Morbidity findings for divisions within the department.

Meetings, Reports, and Recommendations. The Primary Care Services Committee shall meet at least two (2) times annually, shall maintain a record of its proceedings and activities, and shall report to the Comprehensive Review Committee and the Executive Committee.

SURGICAL SERVICES COMMITTEE

Composition. The Surgical Services Committee shall consist of the Chairman of the Surgical Services Department, the Vice Chairman and any other officers of the Surgical Services Department, additional representatives from the Surgical Services Department as designated by the Chairman, a representative from the Pathology Division, the Radiology Division, and the Anesthesiology Division as designated by their respective Medical Directors, the President or his designee, and such representatives of clinical and ancillary support services as designated by the Chairman. The Vice Chairman of the Department shall act as chairman of the committee.

Duties. The Surgical Services Committee shall:

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

(b) Monitor and evaluate the quality and appropriateness of the care provided by members of the Department and select cases for presentation at Department meetings that will contribute to the continuing education of the members of the Department.

(c) Conduct performance improvement activities that relate to department services, including exercising responsibility and oversight over national quality indicators relating to surgical services.

(d) Review Mortality/Morbidity findings for divisions within the department.

Meetings, Reports, and Recommendations. The Surgical Services Committee shall meet at least two (2) times annually, shall maintain a record of its proceedings and activities, and shall report to the Comprehensive Review Committee and the Executive 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.

METHODIST JENNIE EDMUNDSON
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MEDICAL STAFF RULES AND REGULATIONS

The following Rules and Regulations define the parameters surrounding the exercise of Medical Staff clinical privileges and Allied Health Professionals' rights and responsibilities associated with membership or allied health status. In the event of conflict with the Bylaws, the rules and regulations yield to the Bylaws.

1. ADMISSION

1.1 Admission Privileges

Patients may be admitted to the hospital only by a member of the medical staff with admitting privileges. All practitioners shall be governed by the official admitting policies of the hospital.

1.2 Assignment of Attending Physician or Oral Surgeon

Each member of the medical staff who does not reside in the immediate vicinity shall name a member of the medical staff in the area who may be called to attend patients during an emergency. In case of failure to name such an associate, the Chief of Staff, Chairman of the Department concerned, or President shall have the authority to call any member of the staff considered to be appropriate.

A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend him. Where no such selection is made, a member of the Hospitalist Service on call for the hospital will be asked to accept the patient.

1.3 Admission Orders

Each admitting practitioner shall order the admission diagnostic testing which he deems appropriate for his patients. He will be permitted to order these tests by means of an order set, or by giving a specific order at the time of the patient's admission. The order shall include estimated length of stay and anticipated discharge plan. Admission orders shall include clear indication of the level of care to which patient is to be admitted, i.e., inpatient, outpatient surgery, observation.

Patients admitted to observation shall be seen within 23 hours. Any patient in observation status after 24 hours shall be reviewed for medical necessity of continued stay. Medicare patients shall be placed in inpatient if they require a second midnight or if medical necessity for continued stay is determined. In securing the admission of patients, the physician shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever and to assure protection of the patient from self-harm.

2. CONSENT FOR TREATMENT

2.1 General Consent for Treatment

A general consent form signed on behalf of every patient admitted to the hospital must be obtained. If such consent cannot be obtained for any reason, the attending physician shall be promptly notified. Once so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated at the hospital.

2.2 Informed Consent for Invasive Procedures

It is the responsibility of the physician to review the risks, benefits and alternatives with the patient or their representative prior to the procedure. An operation or any invasive diagnostic or treatment procedure shall be performed only upon completion of a specific consent that shall be signed by the patient or his legal representative.

2.3 Informed Consent for Use of an Investigational Therapy or Procedure

Only those drugs and medications approved by the Food and Drug Administration may be administered to patients. Drugs for clinical trials approved by the Hospital IRB/Ethics Committee are the only exceptions to this rule. Such drugs shall be used in full accordance of statement of principles in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration.

2.4 Emergency Consent for Treatment

A surgical operation shall be performed only on consent of the patient or his legal representative except in case of an emergency. An emergency is defined as a condition in which the life of the patient is in immediate jeopardy or the patient's condition will significantly deteriorate unless immediate surgical treatment is instituted. In an emergency situation, where the life and welfare of the patient is in immediate jeopardy unless prompt medical or surgical treatment is instituted, this requirement may be waived.

In emergencies involving a minor or unconscious patient, in which valid consent for surgery cannot be immediately obtained, the circumstances shall be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

3. GENERAL CARE PROCEDURES

3.1 Consultations

The attending physician is responsible for requesting consultation when indicated. In the event a consultation is requested the consulting physician shall examine the patient within 24 hours. It is the duty of the medical staff, through the Peer Review Process, to make certain the members of the staff do not fail in the matter of calling consultations or responding to consultations as needed or required.

Consultations shall show written evidence of a review of the patient's record by the consultant, pertinent findings and examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the medical record. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the operation.

3.2 Mandatory Consultations

Mandatory consultations shall be performed by a member of the medical staff in the appropriate specialty, who is board certified by an appropriate National specialty board, board eligible, or is qualified by training and experience. A consultation shall be mandatory in all procedures for therapeutic termination of pregnancy. In any case in which a patient is suicidal or homicidal, a consultation with a psychiatrist is mandatory.

Consultations shall be mandatory in all cases in which according to the judgment of the physician the patient is not a good risk for operation or treatment, the diagnosis is obscure; there is doubt as to the best therapeutic measures to be utilized; a case that is unusually complicated and the specific skills of other practitioners may be needed; the patient’s condition has deteriorated in an unexpected or inexplicable manner; the patient does not show improvement within the normal expected time or where consultation is otherwise required in these rules and regulations.

3.3 Questions About Orders

If a nurse, after having conferred with the attending physician, has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of his or her supervisor who, in turn, may refer the matter to the VP of Medical Affairs or his designee, who may request a consultation.

4. EMERGENCY SERVICES

4.1 Medical Screening

Any individual who presents to the hospital and on whose behalf medical examination or treatment is requested, shall receive a medical screening examination, treatment, stabilization and transfer (if appropriate) in accordance with applicable laws and regulations. The following health care professionals are qualified and authorized to perform medical screening examinations:

- Emergency Services physicians with appropriate clinical privileges.
- Mid-Level Practitioner with appropriate clinical certifications, pursuant to department policies.
- Hospital-employed registered nurses, pursuant to department policies.

4.2 On-Call Roster

Physician services shall be available for the emergency treatment of patients. The Emergency Center is staffed 24 hours per day by an emergency physician. All members of the Active Medical Staff shall agree, on an equal rotation basis, to provide on-call services to this area. Assignment of patients presenting without an established patient physician relationship shall be triaged by the Emergency Center physician to one of the clinical services of the Medical Staff and that assignment within the service shall then be pursuant to Emergency Center policies to a Hospitalist, medical specialty or surgical specialty with appropriate clinical privileges on the basis of call rosters maintained in the Emergency Department. Acceptance of patients pursuant to this mechanism is mandatory. All assignments shall be made without regard to the payment status of the patient.

4.3 Medical Emergency

Emergency physicians are members of the team responding to Medical Emergency situations. The first physician physically on the scene shall be responsible for the Medical Emergency and all orders relative to the Medical Emergency until such time as he/she relinquishes responsibility to another physician. Appropriate physicians are expected to respond to "Code Trauma" alert and follow approved protocols as defined by the Area Trauma Guidelines.

4.4 Emergency Services Transfers

Patients with conditions whose definitive care is beyond the capabilities of MJE shall be referred to the appropriate facility when in the judgment of the attending practitioner or emergency service physician, the patient’s condition permits such a transfer.

4.5 Admission Notifications

All admissions to observation or inpatient status in the Hospital shall be communicated by the attending Emergency Services **physician** to the accepting admitting physician or AHP.

5. MEDICAL RECORDS

5.1 General Rules of Medical Record Documentation

Medical records shall be done in the electronic medical record. Documentation in the medical record shall be legible, timely, pertinent, accurate, reflective of the treatment rendered and the patient's response to that treatment, and consistent with professionally recognized and hospital-specific standards of content and form. All medical record entries will be timed, dated and signed and placed in our electronic medical record.

5.2 Basic Content and Component-specific Time Frames

The attending practitioner shall be responsible for the preparation of a complete (signed and dated) and legible medical record for each patient.

Its contents shall be pertinent and current. This record shall include:

a. component time frame for completion
b. patient identification data on admission
c. attending physician's I.D. on admission

d. history and physical examination and/or H&P update within 24 hours of admission
e. physician's verbal order-within 48hours
f. consultation reports 24 hours after consult
g. clinical laboratory reports 24 hours after test
h. radiology reports 24 hours after exam
i. reports of medical/surgical treatment as administered
j. immediate post-operative note immediately
k. operative report 24 hours after surgery
l. informed consent prior to any treatment requiring specific consent
m. progress notes daily
n. ancillary reports 24 hours after test/exam
o. pathologic findings 24 hours after exam
p. final diagnosis at discharge
q. discharge summary within48 hours of discharge
r. autopsy report anatomic - 3 days complete - 60 days

5.3 History and Physical

A complete History and Physical exam will include:

- Chief Complaint
- History of Present Illness
- Relevant Past, Social and Family History
- Review of Systems
- Current Medications and Allergies
- Relevant Physical Exam
- Provisional Diagnosis/Impression
- Plan

5.4 History and Physical Completion by Mid-Level Practitioner

If a mid-level practitioner performs the medical history and physical examination, the findings, conclusions, and risk assessments shall be confirmed or endorsed by the physician prior to any potentially hazardous therapeutic or diagnostic procedure or within 24 hours, whichever occurs first.

5.5 History and Physical Completion by Member of Medical Staff Prior to Admission of Patient

If the complete history has been recorded and the physical examination performed within 30 days prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports which are in a form acceptable to the hospital and compatible with its current medical record system may be used in the patient's hospital medical record in lieu of the admission history and physical examination provided these reports were recorded by a member of the medical staff. In lieu of a new H&P, an H&P Update must be completed within 24 hours of admission and/or prior to procedure and include changes in condition of patient and risks and benefits. A referring physician who is not a member of the Medical Staff may complete the history and physical, provided a physician on the Medical Staff authenticates the document.

5.6 History and Physical Completion Prior to Surgery Procedure Requiring Level II, III, IV Sedation

All anesthesia except local/regional requires a history and physical on the chart prior to surgery/procedure. When such history and physical is not on the chart before the time of operation/procedure, the procedure shall be canceled unless the attending practitioner states in writing that such delay would be detrimental to the patient.

5.7 History and Physical Completion Prior to Outpatient Procedure

In those instances in which an outpatient has full and functional protective reflexes, and in which no anesthetic except local is used, a relevant History and Physical examination shall be defined

as consisting of a documented and signed certification by the physician describing the physical condition of the patient, stating that the examination or procedure contemplated poses no apparent significant risk to the patient, and a written indication of why the procedure is being done. This document should include the elements of an informed consent if not documented elsewhere in the preoperative record.

5.8 Immediate Post-Operative Note

The Immediate Post op Note must be completed prior to the surgeon leaving the surgical area or proceeding to another case and prior to the patient leaving PACU. The note must contain the following elements:

- Preoperative Diagnosis
- Postoperative Diagnosis
- Anesthesia
- Name of Operation (Procedure)
- Name of Surgeon and Assistant(s)
- Wound Class
- Complications

5.9 Operative Report

Operative reports shall include a detailed account of findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated within 24 hours after surgery and the report, when received, promptly signed by the surgeon and made a part of the patient's current medical record. Operative reports will contain at least the following elements:

- Date of Procedure
- Indication
- Preoperative Diagnosis
- Postoperative Diagnosis
- Anesthesia
- Name of Operation
- Name of Surgeon and Assistant(s)
- Findings
- Description of Technical Procedures
- Specimen(s) Removed
- Estimated Blood Loss
- Complications
- Disposition of Patient
- Signature of Surgeon/Date

5.10 Obstetrical Admission

Obstetrical records will include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the hospital before admission, shall be in a form approved by the hospital and compatible with the hospital's medical record system. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings that may have occurred since the last entry on the prenatal record and admission to the hospital.

Obstetrical admission with surgery requires a complete prenatal record and a current history and physical examination. An H&P update is required prior to C-Section deliveries.

5.11 Psychiatric Admission

Any patient with a primary psychiatric diagnosis must be under the care of a psychiatrist. If the patient’s medical condition permits, the patient shall be admitted to the Psychiatric Unit. If the patient’s medical condition is unstable, and the patient presents a risk of harm to himself and/or others, the patient shall be admitted to the Intensive Care Unit.

5.12 Inpatient Hospitalization - Psychiatric

A complete history and physical which includes a complete psychiatric and medical history and physical must be completed within 24 hours of all psychiatric admissions. The psychiatric history and physical shall include, at a minimum:

- DSM V Multiaxial Classification of the patient's diagnostic and functional status;
- Pertinent psychiatric history;
- Mental status; and
- Treatment plan, including rationale and reference to patient's clinical psychiatric and medical status.

5.13 Acute Care Progress Notes

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlate with the specific orders as well as results of tests and treatments. Progress notes shall be written at least daily by all services acutely involved in the patient's care.

5.14 Discharge Summary/Final Diagnosis Notes

A discharge summary shall be completed for all inpatient and outpatient admissions over 48 hours, except normal newborns and normal obstetrical deliveries. A final progress note shall be sufficient for patients hospitalized less than 48 hours, normal newborns and normal obstetrical deliveries. The final progress note must contain the outcome of hospitalization, the case disposition, any provisions for follow-up care, and a final diagnosis.

Notwithstanding the guidelines above, a discharge summary shall be completed for all transfers to other acute care facilities and inpatient deaths, regardless of length of hospitalization.

5.15 Emergency Department Record

A record shall be generated each time a patient is assessed and/or treated in the emergency department. This record will include the following:

- consent for care
- patient identification and demographic information arrival time
- pertinent history of the illness or injury and physical findings, including the patient's vital signs and allergies
- emergency care provided to the patient prior to the arrival
- mode of transportation
- diagnostic and therapeutic orders
- clinical observations, including results of treatment
- reports of procedures, tests and results
- diagnostic impression
- conclusion at the termination of evaluation/treatment, including final disposition, and the patient's condition on discharge or transfer
- instructions for follow-up care; written follow-up instructions for patients seen on a prearranged or appointment basis in the emergency department shall be at the discretion of the physician involved.
- Consent for release of information to legal authorities when indicated

This record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

5.16 Attending Physician and Dentist Responsibilities

A patient receiving dental care is a dual responsibility involving the dentist and a physician member of the medical staff. The dentist's responsibilities include a detailed history; detailed description of the examination of the oral cavity and preoperative diagnosis; and complete

operative report describing the findings and technique. In case of extraction of teeth, the doctor shall clearly state the number of teeth and fragments removed. Progress notes as are pertinent to the oral conditions and a discharge summary/final progress note are the dentist's responsibility. The physician's responsibilities include a medical history pertinent to the patient's general health, a physical examination to determine the patient's ability to withstand anesthesia and surgery, and supervision of the patient's general health status. Discharge of the patient shall be on written order of the dentist member of the medical staff.

5.17 Attending Physician and Podiatrist Responsibilities

The Podiatrist is responsible for the part of their patients' history and physical examination that relates to podiatry. The podiatrist's responsibilities include a detailed history; detailed description of the examination of the lower extremity and preoperative diagnosis; and complete operative report describing the findings and technique The physician's responsibilities include a medical history pertinent to the patient's general health, a physical examination to determine the patient's ability to withstand anesthesia and surgery, and supervision of the patient's general health status. Progress notes as are pertinent to the lower extremity conditions and a discharge summary/final progress note are the podiatrist's responsibility. Discharge of the patient shall be on written order of the podiatrist member of the medical staff.

5.18 Record Completion at Discharge

The patient's medical record shall be completed (dictated/documented and signed manually or electronically) by all physicians attending that patient within thirty (30) days after the discharged patient's record has been assembled and the analysis process completed by the Department of Health Information. A weekly inpatient and outpatient surgery record list delineating the age of each medical record outstanding will be made available to each physician. The medical record shall include all appropriate content listed in the section of 5.2 Basic Content and Component-specific Time Frames in the medical staff Rules and Regulations.

Request for extension of the thirty (30) day count must be in writing and requires the written approval of one of the following: the Vice President of Medical Affairs, Chief of Staff or Medical Staff Department Chairman. Failure to comply with this regulation shall cause suspension of all privileges effective on the 35th day until overdue records are completed. A letter will be sent to the physician on the 31st day notifying them of the suspension. All correspondence sent is presumed to be received three (3) days after deposit in first class U.S. Mail to the individual's office address or placed in the physician's mail box located in the dictation area of the Health Information Management Department.

A medical record shall not be permanently filed until it is completed by the physicians attending a patient or ordered filed incomplete by the Comprehensive Review Committee.

6 Orders

6.1 Orders for Treatment

All orders for treatment shall be entered into the computer. A verbal order shall be considered to be electronically entered if dictated to and entered by a Registered Nurse, Licensed Practical Nurse, or the following ancillary personnel pertaining to their respective scope of service/specialty: Dietitian, Pharmacist, Physical and Occupational Therapist, Radiology Technician, Respiratory Therapist, Speech Therapist, Sonographers, Electrodiagnostic Technicians and Addictions Counselors.

The ordering practitioner or practitioner responsible for care of the patient shall sign verbal orders within 48 hours. Other orders shall be signed no later than 30 days following a patient's discharge unless legal requirements permit otherwise. Orders that are not clearly understood shall not be carried out until understood by the party carrying out the order.

6.2 Standing Outpatient Orders
Standing orders for patients undergoing an extended course of outpatient treatment shall be maintained in the Patient Services Department. All standing orders shall contain patient name or identifier, tests requested, effective date, valid period or end date, and be signed by the attending practitioner. Standing orders shall be reproduced in detail on the order sheet of the patient's record which shall then be signed and dated by the practitioner. Standing orders shall be valid for six months.

6.3 Medication/Stop Orders
The Pharmacy & Therapeutics Committee will make recommendations to the Executive Committee regarding appropriate medication stop orders. Such policy shall be updated and monitored from time to time. Orders for some medications shall be automatically discontinued or therapeutically interchanged pursuant to policies established by the Pharmacy & Therapeutics Committee.

6.4 Intravenous Medications
A list of selected intravenous medications and the patient care unit authorized to administer them has been approved by the Medical Staff Executive Committee.

6.5 Symbols and Abbreviations
Only those symbols and abbreviations which have been approved by the medical staff shall be used. Medical staff shall also establish a list of symbols and abbreviations that must NOT be used.

6.6 Security of the Medical Record
All records are the property of the hospital. Written authorization of the patient is required for release of medical information to persons not otherwise authorized to receive this information. The record must accompany the patient for all invasive procedures and when the record does accompany a patient, it must return with the patient to the unit. Mental health records will be forwarded at the discretion of the attending physician.
Records may be removed from the hospital only with permission of the Hospital President or designee, a court order, subpoena, or statute. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period of time to be determined by the Executive Committee of the Medical Staff.

6.7 Research Requests
Physicians desiring to access patient records in order to conduct research or other studies shall submit their research/study proposal to Administration for review and approval by the Institutional Review Board.

7. SURGERY

7.1 Preparation Before Administration of Anesthesia
The results of pertinent laboratory and diagnostic tests, x-ray procedures, the history and physical, the preoperative diagnosis, and required informed consent and consultation shall be on the chart prior to performance of any non-emergent surgical procedure. A note describing the patient's condition prior to induction of anesthesia and start of operation is required for a declared emergency. Physicians administering or directing administration of moderate or deep sedation and anesthesia must be qualified and have the appropriate credentials and privileges.

7.2 Requirements for Pathological Examination
Refer to Pathology Service Policy

7.3 Authorized Personnel in Surgery Suite

Personnel authorized to be present in surgical suites includes: surgeons; anesthesia personnel; operating room personnel; nursing students with a clinical instructor; physicians, medical students and premedical students under supervision of a physician; medical residents in approved residency programs and rotations and other physicians or personnel directly involved in performing a specific service. In addition, medical device representatives approved by the surgeon and scheduled to be present are authorized to attend a surgery to provide verbal instruction to surgeon(s) but may not act as assistants. The Surgery Services Executive shall be notified in any case in which a non-approved individual has been proposed to observe surgery. Observers (e.g. student shadowing) not directly involved in performing a specific service may be allowed in the operating suites at the discretion of either the surgeon and/or the Surgery Services Executive provided the following conditions are met:

a. The Surgery Services Executive is notified that an observer will be present,
b. A consent is signed by the patient prior to the procedure acknowledging that an observer shall be present during the surgery, and
c. A confidentiality statement is signed by the observer.

8. DISCHARGE

8.1 Discharge Order

Patients shall be discharged only on the written order of the admitting physician unless such authority is delegated in writing to another physician. Should a patient leave the hospital against the advice of the attending physician, without proper discharge, patient will be requested to complete a form indicating that he has been discharged against medical advice. Notation of the incident shall be made in the patient's medical record.

8.2 Discharge Planning

To facilitate a smooth transition to the next level of care, discharge planning shall begin upon admission. Discharge shall be anticipated at the point that the patient no longer meets criteria for continued stay based upon medical necessity.

9. AUTOPSIES

Autopsies may only be performed with the proper authorization as follows:

a. Ordered by court or directed by the authorized public agency, official or coroner;
b. Pursuant to an authorization signed by the person having the right of custody of the body in accordance with current Iowa law.

The Medical Staff shall attempt to secure autopsies in deaths that meet the following medical staff-approved criteria:

- Deaths in which an autopsy may help explain unknown or unanticipated medical complications.
- Deaths in which the cause is not known with certainty on clinical grounds.
- Deaths in which an autopsy may help allay concerns or provide reassurance to the family.
- Unexpected or unexplained deaths occurring within 48 hours of any dental, medical, surgical, or diagnostic procedures and/or therapies.
- Deaths occurring in patients who have participated in clinical trials or protocols that are approved by the Medical Staff.
- Deaths resulting from high risk infectious and contagious diseases.
- Deaths incident to pregnancy or within seven (7) days following delivery.
- Neonatal and pediatric deaths.
- Deaths occurring in the outpatient setting.
- Unexpected deaths occurring in the Psychiatric Unit.

10. MEDICAL STUDENTS, RESIDENTS, AND FELLOWS

All medical students, residents and fellows must be registered in the Administration office prior to the start of their rotation, and an agreement must be in effect between the medical student's school and the hospital. They must wear identifying insignia and medical attire. Since all patients have a right to know the identity and status of caregivers, medical students and residents shall identify themselves to patients and family as being under the supervision of their supervising physicians and as being enrolled in an approved school of medicine or program of graduate medical education. They shall comply with all policies, rules and regulations of the hospital, and any conditions imposed by the Medical Staff.

10.1 Resident/Fellow Orders/Documentation

Resident/Fellow physicians may initiate patient care orders subject to supervision of the supervising physician. A resident/fellow may document care provided in the medical record and perform and record a History and Physical examination subject to authentication by the attending physician.

10.2 Medical Student Documentation

Medical students may initiate written patient care orders, but such orders are not effective until approved by the attending physician. Approval may be in writing (by countersigning) or verbal with later countersignature within the time frames established for verbal orders. Medical students may not initiate orders for controlled substances.

11. PROFESSIONAL CONDUCT

All physicians and their supervised PAs and ARNPs who are credentialed and privileged for in-patient care have the ethical, moral and professional responsibility to immediately respond to Medical Emergencies (cardiopulmonary arrest), Code Triage (mass casualty events), and Trauma Alert (multiple trauma).

12. PERFORMANCE IMPROVEMENT

It is the responsibility of the Hospital's Board of Directors, Medical Staff, and Administration to monitor the quality and effectiveness of care provided, as well as to identify improvement opportunities which will enhance the quality and/or effectiveness of that care. Members of the Medical Staff are expected to participate in the performance improvement program to ensure that the care provided is evidence based.

The Executive Committee of the Medical Staff delegates functions related to quality of care to the Medical Staff departments and committees. All monitoring and evaluation topics identified or discussed by the departments or committees shall be documented in the minutes of the meetings.

Pertinent findings of performance improvement activities will be reported at least quarterly to the President and/or Executive Committee of the Medical Staff. These reports will then be summarized and reported at least quarterly to the Board of Directors. Reports shall include concerns identified and resolved during the reporting period and the status of those awaiting assessment, corrective action, and resolution.

A written evaluation of the impact of the Performance Improvement program and suggested changes in the plan shall be submitted annually to the President, or his designee, who will then review and comment on these suggestions. The evaluation and suggestions will be forwarded to the Executive Committee for their action and recommendation to the Board of Directors. This reappraisal of the Performance Improvement Program shall be conducted annually and become effective when approved by the Board of Directors.

13. PATIENT RIGHTS

The hospital's policies on patient rights are binding on the Medical Staff. All patients have the right to be involved in their own health care decision making. Clinical decisions will be based upon identified health care needs and shall not be compromised in response to financial considerations.

14. ADVANCE DIRECTIVES

Iowa law recognizes a patient's right to formulate advance directives including a living will and durable power of attorney for health care. The medical staff shall adhere to the hospital policy relating to advance directives and shall transfer a patient if the physician is not willing to follow the patient's wishes.

15. PRIVACY RULES APPLICABLE TO PRACTITIONERS

The Hospital has adopted a formal Compliance Plan to address its responsibilities under the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Parts of the Compliance Plan are made applicable to practitioners at the Hospital by this Rule.

DEFINITIONS

Practitioner means an individual who has been granted clinical privileges at the Hospital.

Covered practitioner means a practitioner who is directly regulated as a covered health provider under HIPAA.

Non-covered practitioner means a practitioner who is not directly regulated by HIPAA.

Protected health information means information that relates to the past, present or future physical or mental health, health care or condition of an individual or payment for health care, including identifying demographic information, which identifies an individual, regardless of whether the information is gathered, stored or transmitted in written, electronic or even oral form.

Health care operations means those activities which practitioners engage in on behalf of the Hospital, such as Hospital and Medical Staff quality improvement, utilization management, peer review, and similar functions, which involve access to protected health information. Medical Staff committee and departmental activities are typically health care operations.

Patient means the individual whose information is protected under HIPAA (usually a registered inpatient or outpatient). The term includes personal representatives entitled to make health care decisions on behalf of individuals.

15.1 Coverage. All practitioners are covered by this Rule. Practitioners who are **covered practitioners** are also subject to subsection c and automatically participate with the Hospital in an organized health care arrangement as described below. Practitioners who are **non-covered practitioners** are subject to subsection d and must provide the Hospital with a signed business associate agreement. All **practitioners** are subject to the rules governing information practices in subsection e.

15.2 Organized Health Care Arrangement. The Hospital is a clinically integrated care setting in which individuals typically receive health care from Hospital personnel and practitioners. As permitted under HIPAA, all covered practitioners participate with the Hospital in an organized health care arrangement or "OHCA" with the following characteristics:

1. **Description.** The OHCA is an arrangement among the Hospital and covered practitioners under which:
    i. They satisfy their separate notice and acknowledgement requirements under HIPAA by posting and delivery of a joint Notice of Privacy Practices and obtaining or documenting efforts to obtain a single acknowledgement of receipt;\
    ii. They individually agree to follow the information practices described in the joint Notice of Privacy Practices; and
    iii. Covered practitioners may access and use protected health information from Hospital records in order to perform health care operations.
2. **Subject Matter**. The arrangement covers only information practices related to:
    i. Inpatient and outpatient encounters at the Hospital involving Hospital patients; and
    ii. Health care operations of the Hospital.

Records and designated record sets covered by the arrangement consist of existing Hospital records and designated record sets identified in Hospital policies and procedures.

3. **Excluded Subjects**. This arrangement expressly *does not cover*:
    i. Information practices, protected health information, records and designated record sets of practitioners and their practice groups relating to their private office practices or their other (non-Hospital) practice sites – for example, their separate office clinical and billing records or their records or practices at other hospitals and facilities.
    ii. Activities other than information practices – for example, this arrangement does not pertain to the actual care or services of the participants. Under no circumstances shall this Rule or the organized health care arrangement imply joint and several responsibility for clinical services or alter in any way the independent status of the participants in the OHCA to one another.
4. **Joint Notice of Privacy Practices**. The Hospital's Notice of Privacy Practices will be drafted to describe the organized health care arrangement and its participants and to serve as the joint Notice of Privacy Practices. This notice will:
    i. Describe service delivery sites covered by the notice;
    ii. Describe the participants in the arrangement; and
    iii. State that the joint notice covers only Hospital sites and records and does not cover the information practices of practitioners in their offices or at other sites.
5. **Acknowledgment**. The Hospital, following its established policies and procedures, will be responsible to obtain or document reasonable efforts to obtain the patient's signed acknowledgement of receipt.

15.3 Business Associate Agreements. Non-covered practitioners, in order to participate fully in health care operations, must execute and return a business associate agreement on Hospital's standard form and thereafter comply with the terms and assurances therein.

15.4 GENERAL TERMS

The following terms apply to both covered practitioners and non-covered practitioners:

15.41 Notice of Privacy Practices. The Hospital's Notice of Privacy Practices governs access to and use and disclosure of protected health information by all practitioners when using Hospital protected health information or engaging in activities at the Hospital.

15.42 Disclosures for Treatment and Payment Purposes of Practitioners.

As a convenience to practitioners, the Hospital may furnish protected health information to practitioners, and practitioners may request, use and disclose protected health information from the Hospital, for the treatment and payment purposes of such practitioners, without consent, authorization or other special permission, provided that the following conditions are met:

i. The requesting practitioner must have or be about to have a treatment relationship with the patient supporting the need for the information.

ii. The practitioner (and those for whom the practitioner is responsible) must use and disclose information furnished by the Hospital solely for treatment or payment purposes.
iii. The manner of furnishing protected health information to practitioners for their treatment and payment purposes will be per guidelines or arrangements established by the Hospital.
iv. Each practitioner who is subject to this Rule will be presumed to meet the conditions for disclosure, unless the Hospital has information of a pattern or practice by such practitioner (or his or her group) constituting a material breach of this Rule.

15.43 Voluntary Restrictions. From time to time, patients may request that the Hospital voluntarily accept restrictions or limitations on how it uses or discloses protected health information about the individual. The Hospital has designated the Privacy Officer to receive and act on such requests. No individual practitioner may agree to or accept voluntary conditions or restrictions requested by the patient, if the effect could be binding on the Hospital or other practitioners. All requests for acceptance of voluntary conditions or restrictions must be referred to the Hospital for consideration and processing.

15.44 Reporting and Mitigation. Practitioners must promptly report to the Hospital's Privacy Officer any improper use or disclosure of protected health information constituting a material breach of this Rule of which they have first-hand knowledge in order that the Hospital may determine whether any harmful effects may be mitigated. This reporting requirement includes improper use and disclosure by the reporting practitioner, members of his or her office staff (with respect to Hospital protected health information covered by this Rule), other practitioners and members of the Hospital's workforce.
Each practitioner must cooperate in efforts to mitigate the harmful effects of any improper use or disclosure attributable to such practitioner or people for whom such practitioner is responsible, such as members of his or her office staff.

15.45 Access Controls. Practitioners are responsible, in addition to the requirements in this Rule, to follow all access controls established by the Hospital. Where policies permit access by members of a practitioner's office staff, practitioners will be responsible for the compliance of their office staff.

APPENDIX A

I. GENERAL RULES REGARDING OBSTETRICAL CARE

1. There must be a documented reason prior to scheduling an induction. The number of scheduled events i.e., version, induction, stress test, etc. shall not exceed the number allowed pursuant to Birthing Center policies. In the event of conflict, priority cases will be determined by medical necessity.
2. A qualified labor and delivery registered nurse is authorized to perform a medical screen to determine if a woman is in active labor.
3. All therapeutic abortions shall be approved by the therapeutic abortion committee pursuant to hospital policy.

II. GENERAL RULES REGARDING SURGICAL CARE

1. A surgeon may not perform an operation or surgical procedure except those for which he is privileged.
2. All persons should wear proper attire when in the restricted areas of the surgical department. Proper attire is defined as Jennie Edmundson Hospital provided scrub suits, Jennie Edmundson Hospital designated footwear, hair covering, and while in the operating room, a surgical mask.
3. The surgeon should be in the operating room ready to commence operation at the time scheduled. It will be the responsibility of the OR staff to keep surgeons informed of the

scheduled time for their case. It will be the surgeon's responsibility to inform the OR staff of any delay on their part.

4. An 0800 start time is defined as the time the patient is in the operating room. All other cases shall be scheduled as "to follow" although every effort will be made to meet specific time requests. The first case must be recognized as an estimate for scheduling purposes and will not relieve the surgeon of his obligation to maintain an awareness of the probable starting time of his "to follow" case.
5. The operating room shall be held for a maximum of ten (10) minutes after the "scheduled time." In the event the surgeon is not present and ready to commence operation by the end of the ten (10) minute period, the case shall be canceled or, at the sole discretion of the operating room Director, assigned to a later position on the schedule. An extension of the grace period may be granted at the sole discretion of the Director. Any dispute arising from the application of this rule will be resolved post-facto at the departmental or committee level.
6. A surgeon who is late for a first case more than twice in a six-month period shall not be eligible for a first case schedule time for the next 90 days unless there is a first case slot that has not been filled by another surgeon. Excuses for first case tardiness in unavoidable circumstances will be referred to the Chairman of the Surgical Services Department to determine if the surgeon's scheduling time shall be restricted. A follow-up letter will be sent to the surgeon explaining the rule and time frame the restriction is in effect.
7. If a surgeon chooses to leave the OR between cases it is imperative that he be available to return to the department within a 5 minute period. Any consistent abuse of this rule will be referred to the Chairman of the Surgical Services Department.
8. The surgeon shall be responsible for obtaining consent from the surgical director for all personnel in the surgical suite not a part of the designated operating team (i.e., vendors, students, other physicians, etc.)
9. A surgical operation shall be performed only with the consent of the patient or his legal representative except in case of an emergency. An emergency is defined as a condition in which the life of the patient is in immediate jeopardy or the patient's condition will significantly deteriorate unless immediate surgical treatment is instituted.
10. In emergencies, when valid consent for surgery cannot be immediately obtained, the circumstances shall be fully explained on the patient's medical record. A consultation may be desirable before undertaking an emergency operative procedure if time permits.
11. Scheduling:
    a. Emergency cases so declared by the operating surgeon shall be performed at any time the surgeon directs. Any abuse of the provision shall be reviewed and appropriate action recommended to the Department of Surgical Services by the Surgical Services Committee of the Comprehensive Review Committee.
    b. The active, courtesy**,** consulting and associate staff may schedule cases on the first come-first served basis with the relationship between concurrent and consecutive cases to be determined by the operating room Director or her designee.
    c. Elective surgery shall routinely be scheduled on the basis of availability from 0800 to 1530 hours. After 1530 hours, two surgical lines will be available until 1730. When these lines are, in the opinion of the operating room Director or designee, completely full, scheduling for that day shall be discontinued unless availability of anesthesia for an additional line is guaranteed in advance to allow for scheduling. Challenge of this decision shall be resolved by the Chairman of the Surgical Services Department.
    d. A surgeon may also change the order of the consecutively scheduled cases in which he follows himself in the same room.
    e. The procedure for delaying cases to accommodate an emergency shall be in the following sequence:

i. First, bump same specialty block as the emergency case first, e.g., appendectomy to general line.
ii. Second, bump case that would create in the opinion of the operating room Director and Anesthesia Division the least amount of disruption.
iii. The surgeon bumping another surgeon's case for an emergency shall discuss the situation with that surgeon so that there is a clear understanding and collegial effort.

f. No elective cases shall be scheduled prior to 0700 or started after 1700 hours unless the elective case was bumped by an emergency.

12. **Post Anesthesia Care Unit:** Patients recovering from anesthesia may be taken to the Post Anesthesia care Unit (PACU). On call PACU staff is available for recovering patients after hours. Discharge from the PACU is per attending anesthesiologist and/or discharge criteria established and approved by the Medical Staff.

III. GENERAL RULES REGARDING INTENSIVE CARE UNIT (ICU)/TELEMETRY UNIT

1. Patients are eligible for admission to ICU/Telemetry Unit utilizing established admission criteria. Patients who meet admission criteria are admitted by order of the Medical Staff to ICU/Telemetry Unit. The ICU is not intended for palliative care patients.
2. The Medical Director of ICU may convene a Multidisciplinary Cardiopulmonary Committee as appropriate. Members of this committee may include, but are not limited to, a Cardiologist, Emergency physician, the Director of Intensive Care Services, Medical Director of ICU, Vice President of Patient Services, Vice President of Medical Affairs, representatives of Emergency Department, Radiology, Respiratory Care, Telemetry, and Performance Improvement.
3. The length of stay in ICU/Telemetry Unit will be determined by the medical condition of the patient. Established transfer criteria shall be followed.
4. If there is a patient requiring admission to ICU or Telemetry Unit and the units are at capacity, approved admission/discharge criteria guide the process.
5. ICU and Telemetry Unit RN’s may perform the procedures and guidelines for administration of critical intravenous medication that has been approved. ICU and Telemetry Unit RN's are authorized to perform and follow BLS and ACLS protocols, CPR, cardioversion, and defibrillation.
6. Procedures and protocols such as ACLS, CPR, cardioversion and defibrillation may be performed by the ICU RN's in emergency situations outside the ICU.

SUBJECT: Licensed Independent Practitioners Health Issues **Page 1 of 3**

EFFECTIVE DATE: 3/01

REVIEWED/REVISED: 12/03, 3/06, 9/09, 1/13, 12/15

PURPOSE: To provide a process for handling physician impairment issues in a confidential manner.

I. POLICY:

The hospital and its medical staff are committed to providing patients with quality care. The delivery of quality care can be compromised if a Licensed Independent Practitioner (LIP) is suffering from a physical or mental impairment. Issues relating to an LIP impairment may be referred to the Peer Review Committee to address LIP impairment issues in a confidential manner to the extent possible, consistent with quality of care concerns. The Peer Review Committee shall be a function of the peer review process and records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion and are not admissible in evidence in a judicial or administrative proceeding in accordance with Iowa Code Section 147.135.

II. SCOPE

This policy applies to all licensed independent practitioners with clinical privileges at Jennie Edmundson Memorial Hospital.

III. PROCEDURES

1. If any individual has a concern that an LIP may be impaired in any way that may affect his or her practice at the hospital, a written report shall be given to the Chief Executive Officer, the Chief of Staff, or the Vice President of Medical Affairs. The report shall contain a factual description of the incident(s) that led to the concern. In addition, any LIP may request assistance on his or her own behalf.

2. The Vice President of Medical Affairs shall review all reports. If, after discussing the incident(s) with the individual who filed the report, he believes there is enough information to warrant a review, the matter shall be referred to the Peer Review Committee, a function of the peer review process.

3. The Peer Review Committee shall meet as expeditiously as possible. If the Peer Review Committee has reason to believe that the LIP is or might be impaired, it shall meet with the LIP. At this meeting, the LIP should be told there is a concern that he might be suffering from an impairment that affects his practice. The LIP shall not be told the identity of the person who filed the report.

4. The Peer Review Committee may request that the LIP be evaluated by an outside organization and have the results of the evaluation provided to it. An authorization for disclosure of patient information shall be obtained from the LIP to enable use and disclosure of information as necessary and appropriate to such evaluation.

5. Depending on the severity of the problem and the nature of the impairment, the Peer Review Committee may:

    a. Recommend that the LIP voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;
    b. Recommend that the LIP voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the LIP is able to practice safely and competently;
    c. Recommend that some or all of the LIP's privileges be suspended if the LIP does not voluntarily agree to refrain from practicing in the hospital.

In any event, the Peer Review Committee shall monitor the affected LIP and the safety of patients until the rehabilitation or other action is complete; and periodically thereafter depending on the severity and nature of the problem.

6. If the Peer Review Committee recommends that the LIP participate in a rehabilitation or treatment program, it should assist the LIP in locating a suitable program.

7. If the LIP agrees to abide by the recommendation of the Peer Review Committee, then a confidential report will be made to the Chief Executive Officer, the Chief of Staff and the Vice President of Medical Affairs.

8. Upon sufficient proof that an LIP who has an impairment has successfully completed a rehabilitation or treatment program, the Peer Review Committee may recommend that the LIP's clinical privileges be reinstated. Prior to recommending reinstatement, the Peer Review Committee must obtain a letter from the LIP overseeing the rehabilitation or treatment program. The LIP shall execute an authorization for disclosure of patient information to enable the LIP overseeing the rehabilitation and treatment program to provide information to the Peer Review Committee. The letter must address the following:

    a. The nature of the LIP's condition.
    b. Whether the LIP is participating in a rehabilitation or treatment program and a description of the program
    c. Whether the LIP is in compliance with all the terms of the program.
    d. To what extent the LIP's behavior and conduct need to be monitored.
    e. Whether the LIP is rehabilitated.
    f. Whether an after-care program has been recommended to the LIP and, if so, a description of the after-care program; and
    g. Whether the LIP is capable of resuming practice and providing continuous, competent care to patients.

9. The Peer Review Committee may recommend reinstatement to the Chief Executive Officer, in consultation with the Chief of Staff, for approval. Conditions may be included in the reinstatement, such as evidence of continuing treatment, focused and/or ongoing professional practice evaluation, etc.

10. If the Peer Review Committee makes a recommendation and the LIP refuses to abide by the recommendation, the matter shall be referred to the Executive Committee.

11. The original report and a description of any recommendations made by the Peer Review Committee should be included in the LIP credentials file. If, however, the review reveals that there was no merit to the report, the report should be destroyed. The LIP shall have the opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his credentials file.

12. All investigation files, reports, and other information relating to the LIP's health and professional competence in the possession of the Peer Review Committee shall be peer review records under Iowa Code Section 147.135. The records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than the affected LIP or Peer Review Committee and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving discipline against or a proceeding brought by the LIP who is the subject of the peer review record and whose competence is at issue.

13. The hospital shall provide education to hospital staff and all licensed independent practitioners about illness and impairment recognition issues specific to licensed independent practitioners.

14. The hospital will comply with any mandatory reporting obligations regarding changes in an LIP's clinical privileges and/or medical staff membership status.

SUBJECT: Medical Staff Peer Review **Page 1 of 4**

EFFECTIVE DATE: 2/01

REVIEWED/REVISED: 8/02, 3/04, 3/06, 9/09, 12/12, 4/15

PURPOSE: To promote continuous improvement of the quality of care provided by the Medical Staff at Methodist Jennie Edmundson Hospital.

I. POLICY

The Medical Staff shall evaluate medical care provided to ensure appropriate services are rendered in a safety conscious environment. The Medical Staff shall employ effective mechanisms to measure, assess and improve performance.

II. SCOPE

This policy applies to all practitioners holding independent clinical privileges, as well as practitioners who supervise allied health practitioners at Methodist Jennie Edmundson. Pursuant to the Medical Staff Bylaws and as set forth in this policy, 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 pursuant to this policy and to evaluate and make recommendations to the Executive Committee concerning applicants and members.

III. DEFINITIONS

1. "Peer review" means evaluation of professional services rendered by a person licensed to practice a health care profession.

2. "Peer Review Committee" means one or more persons acting in a peer review capacity who also serve as an officer, director, trustee, agent, or member of the medical staff or board of directors when performing a function relating to the reporting by Iowa Code Section 147.135 subsection 3.

3. "Peer review records" means all complaint files, investigation files, reports, and other investigative information relating to licensee discipline or professional competence in the possession of a Peer Review Committee or an employee of a Peer Review Committee. Peer review records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a Peer Review Committee and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving licensee discipline or a proceeding brought by a licensee who is the subject of a peer review record and whose competence is at issue in accordance with Iowa Code Section 147.135.

IV. PROCEDURES

1. Medical Staff peer review activities shall be conducted in the Medical Staff Department meetings and/or by the Peer Review Committee.

2. The Medical Staff peer review process involves the collection of data using a variety of methods including, but not limited to, computer and manual log entries, coding classifications, pathology reports, internal and external databases and referrals.

3. Individual records may be recommended for peer review by the Medical Staff or hospital department managers, nursing staff, patients or family members, or third party payors with quality of care or medical necessity concerns.

4. Events that necessitate peer review include, but are not limited to:

    a. Unexpected death
    b. Unplanned returns to OR for the same condition or to correct the previous surgery
    c. Hospital Acquired Conditions resulting in permanent harm or death
    d. Injury to fetus during delivery
    e. Maternal morbidity requiring 4 or more units of blood and/or transfer to ICU
    f. Maternal death occurring within forty-two (42) days postpartum
    g. Induction of labor prior to 39 weeks gestation with no medical indication
    h. Post-surgical deaths occurring within ten (10) days related to the surgery
    i. Failure to follow medical staff approved protocols such as Stroke or Chest Pain Protocol
    j. Disruptive conduct that impacts patient care.

5. The following procedures shall be followed when a case is referred for peer review:

    a. The case and rationale for referral shall be forwarded to Administration as soon as an occurrence is identified.

    b. Cases sent for review shall be forwarded to a member of the Peer Review Committee for review in a timely manner. The physician reviewer shall determine whether the standard of care has been met. The Physician Reviewer may request additional review by the committee if uncertain

    c. Upon completion of the review the Reviewer shall annotate the peer review evaluation form and return it to administration as follows:

        1. Care Appropriate
        2. Undetermined – reviewer requests additional review
        3. Opportunities are identified for improvement
        4. Minor Deviation from the expected standards is identified
        5. Major Deviation from the expected standard of care is identified

    d. Administration shall compile the case reviews in preparation for presentation to the next scheduled Peer Review Committee The Committee shall be made aware of the cases in each category with the reviewing Physicians presenting review all of the cases.

e. Should information be insufficient for the committee to make a decision, the committee shall gather additional facts surrounding the case from the provider being reviewed or other appropriate personnel. Any request for additional information shall be sent to the provider via certified mail.

f. The Peer Review Committee may request an external peer review if the committee cannot provide an unbiased review internally, lacks the expertise to do a review in a particular area, or otherwise determines the external review is necessary.

g. Once the findings of the review are discussed to the satisfaction of the Peer Review Committee the Committee shall make a determination regarding the case and assign a finding as to category 3-5.

h. The Committee shall relay the findings via certified mail to the affected provider who shall have the opportunity to request an appeal to the Peer Review Committee. The Peer Review Committee may consider, but is not required to grant a request by a provider for external peer review.

i. Recommendations for the corrective action(s) for a provider based on peer review case findings include:

    1. Collegial discussion with the physician involved
    2. Educational letter to the physician with no response required
    3. Educational letter to the physician with written response required
    4. Focused Review and peer mentoring/proctoring
    5. Restriction of privileges
    6. Suspension of privileges
    7. Loss of privileges

j. Documentation of peer review recommendations shall be placed in Peer Review Committee minutes and in the review file of the provider undergoing review. All recommendations are subject to the provisions of the Medical Staff Bylaws and procedures set forth therein regarding fair hearing and appeal rights of an adversely affect provider.

k. Recommendations shall be forwarded to the Medical Executive Committee at least quarterly.

l. The Peer Review Committee shall present an aggregate report of its decisions on at least an annual basis to Medical Executive Committee and the Hospital Board of Directors.

Authorization Signature		Date	
Approved Signature		Date	

Prepared by	Original Date Adopted	Original Approval by
W. O'Donnell	03/15/2007	Harry Chung M.D.

Revised by	Revision Date
D. Ritter	02/11/2013
T. Brandenburg	05/22/2015
Becki G Kahn MD	01/26/2016

Policy of Tissue Exclusion and Exemption

PRINCIPLE:

In compliance with JCH Standards, CAP accreditation guidelines, and in consultation between Pathologists and Medical Staff, the following policies have been developed.

PROCEDURE:

Tissue Exclusion from Pathology Examination:

All tissues and Medical Devices other than those listed below as exclusions must be submitted to the Pathology Department for examination and documentation in the medical record. Those tissues and devices deemed unnecessary for submission to Pathology must have documentation of their removal and disposition included in the Operative or Clinical Procedure Note.

Tissue Exclusion List:

1. Bone, cartilage and soft tissue from rhinoplasty or septoplasty procedures
2. Bone donated to the bone bank
3. Cataracts
4. Foreign bodies that are medico-legal evidence (bullets, etc.) given directly to law enforcement personnel
5. Foreskin from newborns
6. Medical devices without soft tissue that have not contributed to the patient's illness, injury or death (i.e. gastrostomy tubes, stents and sutures, Portacaths, Hickman catheters, ventriculoperitoneal shunts, ureteral stents, etc.) previously placed by surgeons and removed in the perioperative areas are not required to be submitted to the Pathology Laboratory but may be sent at the discretion of the surgeon, unless the device is malfunctioning or otherwise unsafe, or the procedure has resulted in an unanticipated patient outcome (as included in the "Safe Medical Device Act.")
7. Myringotomy ventilation tubes
8. Orthopedic hardware (i.e. plates, screws and prostheses) unless damaged or broken
9. Placentas that are grossly normal and do not meet criteria for examination.

10. Radiopaque mechanical devices removed during surgery
11. Rib segments removed only to enhance operative exposure, provided patient does not have a history of malignancy.
12. Teeth
13. Therapeutic radioactive sources

In the event that such a specimen is indeed submitted for gross or microscopic diagnosis, it will be examined as any other tissue specimen received in the laboratory.

Tissue Exemption from Microscopic Examination:

The Pathologist and/or qualified grossing personnel shall examine all submitted specimens. Only the Pathologist will issue a written report and pathologic diagnosis based on either gross and/or microscopic examination. Both tissue and non-tissue specimens are retained for approximately three weeks with appropriate fixation should occasion arise where additional pathologic evaluation is necessary.

The following is a list of specimens that are exempt from microscopic examination but appropriate for gross examination only. Only if specifically requested by the attending physician, or when the pathologist determines a microscopic examination is indicated by the gross findings or clinical history, will the tissues on the following list be submitted for microscopic examination:

The Following Specimens are Appropriate for Gross Exam Only and Exempt from Microscopic Exam:

1. Bone from arthritis, bunions, deformities of foot and herniated disc cases
2. Calculi (renal, ureteral, bladder)
3. Cicatrix (scar) from prior Cesarean section or cervical disc cases
4. Foreign bodies removed during surgery (non-tissue) unless a foreign body that has been implanted has a permanent alteration in appearance or function; or is removed unexpectedly or prematurely. All tissues, devices or foreign bodies that are not sent to pathology per this protocol must be appropriately documented in the Operative or Clinical Procedure Note
5. Intrauterine contraceptive devices without attached soft tissue
6. Loose bone fragments in a joint
7. Pacemaker devices
8. Tissue expander implants and mammary implants
9. Toenails and fingernails that are grossly unremarkable
10. Tonsils from patients age 12 and under from Jennie Edmundson patients
11. Traumatically injured digits (fingers/toes) for which examination for medical or legal reasons are not deemed necessary.
12. Vaginal foreign bodies (non-tissue)
13. Vaginal mucosa removed during uterine descensus (prolapse) repair
14. Vascular catheters