THREE RIVERS HEALTH SYSTEM, INC

HOSPITAL

MEDICAL STAFF BYLAWS

Revised 09/25/2019

TABLE OF CONTENTS

Page

PREAMBLE 1

DEFINITIONS 1

ARTICLE 1 NAME AND PURPOSES 3
1.1 Name 3
1.2 Purposes and Responsibilities 3

ARTICLE 2 MEDICAL STAFF MEMBERSHIP 3
2.1 Nature of Medical Staff Membership 3
2.2 Relationship of Medical Staff to Hospital 4
2.3 Limitations on Medical Staff Membership 4
2.3.1 Closed-Staff or Limited-Staff Arrangements. 4
2.3.2 Exclusive Contracts 4
2.4 Qualifications for Membership 4
2.4.1 General Qualifications 4
2.4.2 Basic Qualifications 4
2.4.3 Additional Qualifications for Membership 5
2.4.4 Waiver of Qualifications 6
2.5 Effect of Other Affiliations 6
2.6 Nondiscrimination 6
2.7 Administrative and Contract Practitioners 6
2.7.1 Contractors with No Clinical Duties 6
2.7.2 Contractors with Clinical Duties 6
2.8 Basic Responsibilities of Medical Staff Membership 6

ARTICLE 3 CATEGORIES OF THE MEDICAL STAFF 8
3.1 Categories 8
3.2 Assignment and Transfer in Staff Category 8
3.3 Provisional Medical Staff 9
3.4 Active Medical Staff 9
3.4.1 Qualifications 9
3.4.2 Prerogatives 9
3.4.3 Responsibilities 10
3.5 Consulting Staff 10
3.5.1 Qualifications 10
3.5.2 Prerogatives 10
3.5.3 Responsibilities 10
3.6 Courtesy Staff 11
3.6.1 Qualifications 11
3.6.2 Prerogatives 11
3.6.3 Responsibilities 11
3.7 Honorary and Retired Staff 11
3.7.1 Qualifications 11
3.7.2 Prerogatives 12
3.8 Telemedicine Staff 12
3.8.1 Qualifications 12
3.8.2 Prerogatives 12
3.8.3 Responsibilities 12

3.9 General Exceptions to Prerogatives for Limited License Members ... 12
3.10 Affiliate Staff ... 13
3.8.1 Qualifications ... 12
3.8.2 Prerogatives ... 12
3.8.3 Responsibilities ... 12

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT ... 13
4.1 General ... 134
4.2 Applicant's Burden ... 144
4.3 Application for Initial Appointment and Reappointment ... 144
4.3.1 Content of Application ... 15
4.3.2 Basis for Appointment ... 16
4.3.3 Basis for Reappointment ... 16
4.3.4 Extension of Appointment ... 16
4.3.5 Failure to File Reappointment Application ... 16
4.4 Leave of Absence ... 16
4.5 Waiting Period After Adverse Action ... 17
4.5.1 Who Is Affected ... 17
4.5.2 Date When the Action Becomes Final ... 17
4.5.3 Effect of the Waiting Period ... 17
4.6 Confidentiality; Impartiality ... 17

ARTICLE 5 PRIVILEGES ... 18
5.1 Exercise of Privileges ... 18
5.2 Delineation of Privileges in General ... 18
5.2.1 Requests ... 18
5.2.2 Bases for Privilege Determinations ... 18
5.2.2.1 Special Conditions for Podiatric Privileges ... 18
5.3 Conditions for Privileges of Limited License Practitioners ... 18
5.3.1 Admissions ... 18
5.3.2 Medical Appraisal ... 19
5.3.3 Surgery and High Risk Interventions ... 19
5.4 Temporary Privileges ... 19
5.4.1 Circumstances ... 19
5.4.2 Application and Review ... 19
5.4.3 General Conditions and Termination ... 19
5.5 Emergency Privileges ... 20
5.6 Transport and Organ Harvest Teams ... 20
5.7 Proctoring ... 20
5.7.1 General Proctoring Requirements ... 20
5.7.2 Completion of Proctoring ... 20
5.7.3 Effect of Failure to Complete Proctoring ... 21

ARTICLE 6 ALLIED HEALTH PROFESSIONALS ... 21
6.1 Qualifications of Allied Health Professionals ... 21
6.2 Categories ... 21
6.3 Privileges and Responsibilities ... 21
6.4 Procedural Rights of Allied Health Professionals ... 22
6.4.1 Fair Hearing and Appeal Process ... 22
6.4.2 Automatic Termination ... 22
6.4.3 Review of Category Decisions ... 22
6.5 Prerogatives ... 22
6.6 Responsibilities ... 23

ARTICLE 7 MEDICAL STAFF OFFICERS 23
7.1 General Provisions. 23
7.1.1 Identification 23
7.1.2 Qualifications 23
7.1.3 Disclosure of Conflict of Interest 23
7.2 Method of Selection -- General Officers 23
7.2.1 Nomination 24
7.2.2 Election 24
7.2.3 Term of Office 24
7.3 Recall of Officers 24
7.4 Filling Vacancies 24
7.5 Duties of Officers 24
7.5.1 Chief of Staff 24
7.5.2 Vice Chief of Staff 25
7.5.3 Sec/Treas. 24

ARTICLE 8 COMMITTEES 25
8.1 General 25
8.1.1 Designation 25
8.1.2 Appointment of Members 25
8.1.3 Representation on Hospital Committees and Participation in Hospital Deliberations 25
8.1.4 Ex Officio Members 26
8.1.5 Action Through Subcommittees 26
8.1.6 Terms and Removal of Committee Members 26
8.1.7 Vacancies 26
8.1.8 Conduct and Records of Meetings 26
8.1.9 Attendance of Nonmembers 26
8.1.10 Accountability 26
8.2 Medical Executive Committee 26
8.2.1 Composition 26
8.2.2 Duties 26
8.2.3 Meetings 28

ARTICLE 9 DEPARTMENTS 28
9.1 Organization of Departments 28
9.2 Medical Staff Departments 27

ARTICLE 10 MEETINGS 28
10.1 Medical Staff Meetings 28
10.1.1 General Medical Staff Meetings 28
10.1.2 Special Meetings 28
10.2 Committee Meetings 29
10.3 Quorum 29
10.3.1 Medical Staff Meetings 29
10.3.2 Committee Meetings 29
10.4 Manner of Action 29
10.5 Minutes 29
10.6 Attendance Requirements 29
10.6.1 Regular Attendance Requirements 29
10.6.2 Failure to Meet Attendance Requirements 29
10.6.3 Special Appearance 29
10.7 Conduct of Meetings 30

ARTICLE 11 CONFIDENTIALITY, IMMUNITY AND RELEASES ... 30
11.1 General ... 30
11.2 Breach of Confidentiality ... 30
11.3 Immunity and Release ... 30
11.3.1 Immunity from Liability for Providing Information or Taking Action ... 30
11.3.2 Activities and Information Covered ... 30
11.4 Releases ... 31
11.5 Cumulative Effect ... 31

ARTICLE 12 PEER REVIEW AND CORRECTIVE ACTION ... 31
12.1 Participation in Peer Review Activities ... 31
12.2 Peer Review and Corrective Action Process ... 31
12.2.1 Who May Initiate Proceedings ... 30
12.2.2 How Proceedings Shall Be Initiated ... 30
12.2.3 How Proceedings Shall Be Handled ... 30
12.3 Formal Corrective Action ... 32
12.4 Summary Restriction or Suspension ... 32
12.5 Automatic Suspension or Limitation ... 32
12.5.1 Licensure ... 32
12.5.2 Drug Enforcement Administration (DEA) Certificate ... 33
12.5.3 Failure to Satisfy Special Appearance Requirement ... 33
12.5.4 Medical Records ... 33
12.5.5 Cancellation of Professional Liability Insurance ... 33
12.5.6 Failure to Comply with Government and Other Third Party Payor Requirements ... 33
12.5.7 Action by Another Peer Review Body ... 33
12.5.8 Automatic Termination ... 33
12.6 Alternate Medical Coverage for Patients of Suspended Practitioner ... 32

ARTICLE 13 HEARINGS AND APPELLATE REVIEWS ... 34
13.1 Purpose ... 34
13.2 Grounds for Fair Hearing and Appellate Review Process ... 34
13.3 Fair Hearing and Appellate Review Procedure ... 34
13.4 Exceptions to Fair Hearing and Appellate Review Process ... 35
13.4.1 Reasons Not Based on Competence or Professional Conduct ... 35
13.4.2 Failure to Meet the Minimum Qualifications ... 35
13.4.3 Automatic Suspension or Limitation of Privileges ... 35
13.4.4 Failure to Meet Minimum Activity Requirements ... 35
13.4.5 Exclusive Use Departments ... 35
13.4.6 Hospital Contract Practitioners ... 35
13.4.7 Allied Health Professionals ... 36
13.5 Exhaustion of Remedies ... 36
13.6 Intra-Organizational Remedies ... 36
13.7 Board of Trustees Committees ... 36

ARTICLE 14 GENERAL PROVISIONS ... 36
14.1 Rules and Policies ... 36
14.1.1 General Medical Staff Rules ... 36
14.1.2 Departmental Rules ... 36
14.1.3 Medical Staff Policies ... 36
14.2 Forms ... 36
14.3 Dues or Assessments ... 37
14.4 Authority to Act ... 37

ARTICLE 15 ADOPTION AND AMENDMENT OF BYLAWS 37
15.1 Medical Staff Responsibility and Authority 37
15.2 Methodology 37
15.2.4 Technical and Editorial Amendments 37

HOSPITAL
Medical Staff Bylaws

Preamble

WHEREAS, the Three Rivers Health System, Inc is governed by the Three Rivers Health System, Inc Authority, established on November 8, 1979, by an affirmative vote of the people in the governmental units of the city of Three Rivers and the Townships of Constantine, Fabius, Lockport and Park, and organized under the laws of the State of Michigan; and

WHEREAS, it is recognized that no practitioner shall be entitled to medical staff membership and privileges at this hospital solely by reason of education or licensure, or membership on the medical staff of another hospital; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff is to strive for optimal achievable quality patient care in the Hospital, that the Medical Staff must cooperate with and is subject to the ultimate authority of the Board of directors, and that the cooperative efforts of the Medical Staff, Management and the Board of Directors are necessary to fulfill the Hospital's aims and goals in providing optimal achievable patient care to patients in the Hospital;

THEREFORE, the physicians, dentists and podiatrists practicing in the Three Rivers Health hereby organize themselves into a Medical Staff in conformity with these Bylaws.

Definitions

1) **Allied health professional** or **AHP** means an individual, other than a licensed physician, dentist, clinical psychologist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Trustees, the Medical Staff, and applicable state laws, who is qualified to render direct or indirect medical, dental, psychological or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the Hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the Bylaws, Rules and policies of the Medical Staff and the Hospital. AHPs are not eligible for Medical Staff membership. Examples of AHP's include but are not limited to: Advance Practice Nurse Practitioners, Physician Assistants, Certified Nurse Anesthetists, Certified Nurse Midwives, Chiropractors and Psychologists.

2) **Board of Trustees** means the Board of Trustees of HOSPITAL. As appropriate to the context and consistent with the Hospital's Bylaws, it may also mean any Board of Trustees committee or individual authorized to act on behalf of the Board of Trustees.

3) **Bylaws** refer to these Bylaws of the Medical Staff unless otherwise specified.

4) **Chief Executive Officer or CEO** means the person appointed by the Board of Trustees to serve in the top administrative capacity or his or her designee.

5) **Chief of Staff** means the chief officer of the Medical Staff elected by the Medical Staff.

6) **Date of receipt** means the date any notice or other communication was delivered personally; or if such notice or communication was sent by mail, it shall mean 72 hours after the notice or communication was deposited, postage prepaid, in the United States mail.

7) **Ex officio** means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.

8) **Hospital** means Three Rivers Health Hospital.

9) **Limited license practitioner** or **limited license member** means a podiatrist, dentist, or other practitioner who is eligible for Medical Staff membership but who does not hold an M.D. or D.O. degree.

10) **Medical Executive Committee** means the executive committee of the Medical Staff.

11) **Medical Staff** means the organizational component of the Hospital that includes all physicians (M.D. or D.O.), dentists, clinical psychologists, and podiatrists who have been granted recognition as members pursuant to these Bylaws.

12) **Member** means any practitioner who has been appointed to the Medical Staff.

13) **Physician** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

14) **Practitioner** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist.

15) **Privileges** means the permission granted to a Medical Staff member or AHP to render specific patient services and access reasonable and necessary Hospital resources.

16) **Professional review action** means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of a Medical Staff member (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects or may affect adversely the clinical privileges or membership of the physician.

17) **Professional review activity** means an action of the Hospital, the Board of Trustees or the Medical Staff, or any committee or member thereof, taken with respect to a Medical Staff member: (1) to determine whether the physician may have clinical privileges with respect to, or membership in, the Hospital or Medical Staff; (2) to determine the scope or conditions of such privileges or membership; or (3) to change or modify such privileges or membership.

18) **Professional Review Body** means the Board of Trustees, the Medical Staff, and any officer, committee, agent or designee thereof who conducts professional review activity.

19) **Rules** refer to the Medical Staff rules adopted in accordance with these Bylaws unless otherwise specified.

20) **Written Notice** means a written communication delivered personally to the addressee or sent by United States mail or by comparable means, to the addressee at the last address appearing in the official records of the Medical Staff or the Hospital. Written notice is presumed to be effective as of the date it is delivered personally to the addressee or three days after it is mailed.

21) **Services** consist an inpatient admission, inpatient referral, inpatient or outpatient care, interpretation, consultation, or surgical/interventional procedure

Article 1

NAME AND PURPOSES

1.1 Three Rivers Health. The name of this organization shall be the Medical Staff of Three Rivers Health.

1.2 Purposes and Responsibilities. The Medical Staff's purposes are:

1.2.1 To assure that all patients admitted to or treated in the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards considering the Hospital's means and circumstances.

1.2.2 To promote the professional practices and ethical conduct of the Medical Staff members.

1.2.3 To develop and implement, with Board of Trustees approval, a written procedure for determining qualifications for Medical Staff appointment and for determining privileges.

1.2.4 To evaluate the professional competence of practitioners and AHPs and to make recommendations to the Board of Trustees concerning applicants, appointments and reappointments to the Medical Staff and the granting, curtailment and delineation of privileges at the Hospital.

1.2.5 To initiate and maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital pursuant to the authority delegated by the Board of Trustees.

1.2.6 To review and approve policies and procedures directly related to medical care.

1.2.7 To assist the Hospital in establishing and maintaining an effective Hospital-wide quality assurance program to evaluate the provision of care.

1.2.8 To provide for accountability of the Medical Staff to the Board of Trustees.

1.2.9 To organize and support professional education and community health education and support services.

Article 2
MEDICAL STAFF MEMBERSHIP

2.1 Nature of Medical Staff Membership. Medical Staff membership is a privilege and not a right. Appointment to the Medical Staff confers upon the member a license to exercise only those clinical privileges and prerogatives within the Hospital as have been granted by the Board of Trustees. Medical Staff members are not employees, independent contractors, partners or joint venturers of the Hospital unless such a relationship is separately established between the Hospital and the Medical Staff member. A practitioner, including one who has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws.

2.2 Relationship of Medical Staff to Hospital. The Medical Staff as an organization functions as a constituent part of the Hospital. As such, the Medical Staff and its members act on behalf of the Hospital, and not as a separate entity, in performing credentialing, peer review, quality assurance, and other administrative functions. The Medical Staff is responsible to the Board of Trustees in fulfilling the Medical Staff's responsibilities.

2.3 Limitations on Medical Staff Membership

2.3.1 Closed-Staff or Limited-Staff Arrangements. The Board of Trustees shall have authority to limit the number of members on the Medical Staff or in any Hospital department, specialty, or service when the Board of Trustees determines that it is in the best interests of the Hospital and/or patient care to do so. In addition to any other appropriate factor, the Board of Trustees may consider the physical capacity of the Hospital; over-utilization and scheduling concerns relating to Hospital facilities; and the Hospital's capabilities for providing qualified support staff and equipment in specialized areas. Applicants who are denied Medical Staff membership or privileges because of such limitations are not entitled to procedural rights described in Article 13.

2.3.2 Exclusive Contracts. The Board of Trustees shall have authority to enter contracts to provide exclusive or semi-exclusive services for Hospital departments or specialties when it determines that it is in the best interests of the Hospital and/or patient care to do so, e.g., to improve the efficiency of the Hospital; standardize procedures; secure greater patient satisfaction; assure the availability of specific services; contain costs; and improve the quality of care. In the event of a conflict between the exclusive contract and these Bylaws, the exclusive contract prevails. The privileges and Medical Staff membership of practitioners who are not included in the exclusive contract are automatically terminated to the extent their privileges and membership would conflict with the exclusive contract. Excluded practitioners are not entitled to the procedural rights described in Article 13.

2.4 Qualifications for Membership.

2.4.1 General Qualifications. Membership on the Medical Staff and privileges shall be extended only to practitioners who are legally and professionally competent and continuously meet the qualifications, standards and requirements set forth in the Hospital and Medical Staff Bylaws, Rules, and policies. Medical Staff membership (except Honorary Medical Staff) shall be limited to practitioners who are currently licensed or qualified to practice medicine, podiatry, clinical psychology or dentistry in Michigan.

2.4.2 Basic Qualifications. A practitioner must demonstrate compliance with all the basic qualifications in order to have an application for Medical Staff membership accepted for review. The practitioner must:

1. Be licensed to practice medicine or provide health care by the relevant licensing agencies under Michigan law, or qualify under Michigan law to practice with an out-of-state license.

2. If practicing clinical medicine, dentistry or podiatry, have a federal Drug Enforcement Administration (DEA) number.

3. If practitioners hold themselves out as specialists, they must be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, or AOA (American Osteopathic Association), or a board or association with equivalent requirements approved by the Michigan State Board of Medicine in the specialty that the practitioner will practice at the Hospital; or have completed a residency approved by the Accreditation Council for Graduate Medical Education that provided complete training in the specialty that the practitioner will practice at the Hospital; or satisfy such other requirements as deemed appropriate by the Board of Trustees. This section shall not apply to dentists or clinical psychologists.

4. Be eligible to participate in and receive payments from federally and state-funded health care programs, including Medicare and Medicaid.

5. Have liability insurance or equivalent coverage meeting the standards specified in applicable Bylaws, Rules, or policies.

6. Be located close enough (office and residence) to the Hospital to be able to provide continuous care to his or her patients. The distance to the Hospital may vary depending upon the Medical Staff category and privileges which are involved and the feasibility of arranging alternative coverage.

1) Specialty – Hospitalist. The hospitalist must be within a distance of 30 minutes.

7. Pledge to provide continuous care to his or her patients directly or through coverage arranged by the Medical Staff member.

8. If requesting privileges for services that are provided at the Hospital under an exclusive contract, be a member, employee or subcontractor of the group or person that holds the exclusive contract.

9. To the extent that such consideration is allowed by law, not be an owner, member, or participant in a competing health care entity if such membership, ownership, or participation may adversely affect or undermine the Hospital's economic well-being and continued ability to provide quality patient care.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the Honorary Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet one or more of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights described in Article 13, but may submit comments and a request for reconsideration or waiver of the specific standards which adversely affected such practitioner. The applicant shall submit the comments and requests to the Medical Executive Committee, which may consider and make a recommendation to the Board of Trustees. The Board of Trustees shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.4.4, Waiver of Qualifications.

2.4.3 Additional Qualifications for Membership In addition to meeting the basic standards, the practitioner must:

1. Document his or her

1) adequate experience, education, and training in the requested privileges;

2) current professional competence;

3) good judgment; and

4) adequate physical and mental health status (subject to any appropriate reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent to provide the generally recognized professional level of quality of care for this community; and

2. Be determined by the Medical Staff to

1) adhere to the lawful ethics and standards of his or her profession;

2) be able to work professionally and cooperatively with others in the Hospital so as not to adversely affect patient care or Hospital operations;

3) be willing to participate in and properly discharge Medical Staff responsibilities; and

4) Provide quality health care in an appropriate manner so as not to adversely affect the Hospital's continued ability to provide quality patient care.

2.4.4 Waiver of Qualifications. To the extent allowed by applicable law, the Board of Trustees has the discretion to deem a practitioner to have satisfied a qualification if it determines that the practitioner has demonstrated that he or she has substantially comparable qualifications and that a waiver is necessary to serve the best interests of patients and of the Hospital. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws or Rules.

2.5 Effect of Other Affiliations. No practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership or privileges at another health care facility.

2.6 Nondiscrimination. Medical Staff membership or privileges shall not be denied on the basis of age, sex, religion, race, creed, color, national origin, or any impairment if, after any appropriate reasonable accommodation, the applicant is able to comply with the Bylaws, rules, regulations, and policies of the Medical Staff and the Hospital and otherwise provide quality patient care to Hospital patients.

2.7 Administrative and Contract Practitioners.

2.7.1 Contractors with No Clinical Duties. A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

2.7.2 Contractors with Clinical Duties. A practitioner with whom the Hospital contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff and must achieve his or her status by the procedures described in these Bylaws and Rules. Unless a contract or agreement executed after this provision is adopted provides otherwise, or unless otherwise required by law, those privileges made exclusive pursuant to a closed-staff or limited-staff policy or exclusive contract will automatically expire, without the procedural rights described in Article 13 or corresponding Rules, upon termination or expiration of such practitioner's contract or agreement with the Hospital. In the event of a conflict in terms, contracts between practitioners and the Hospital shall prevail over these Bylaws and the Rules.

2.8 Basic Responsibilities of Medical Staff Membership. Except for Honorary Staff, each member of the medical staff and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

2.8.1 Provide his or her patients with care at the generally recognized professional level of quality and efficiency.

2.8.2 Ensure that a physical examination and medical history is done no more than 7 days before or 24 hours after an admission for each patient by a physician, or for patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon who has been granted such privileges by the Medical Staff in accordance with state law.

2.8.3 Prepare and complete in a timely manner the medical and other required records for all patients to whom the practitioner in any way provides services in the Hospital.

2.8.4 Abide by these Bylaws and all other lawful standards, policies and rules of the Medical Staff and the Hospital.

2.8.5 Abide by all applicable laws and regulations of governmental agencies and standards of relevant accreditation agencies.

2.8.6 Abide by the ethical principles of his or her profession.

2.8.7 Maintain the privacy of protected health information as required by applicable laws, regulations, rules, policies or practices.

2.8.8 Work professionally and cooperatively with members, nurses, Hospital administrative staff and others so as not to adversely affect patient care or Hospital operations.

2.8.9 Refrain from any harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, and health status, ability to pay or source of payment.

2.8.10 Refrain from unlawful fee splitting, unlawful referrals or unlawful inducements relating to patient referrals.

2.8.11 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised.

2.8.12 Seek consultation whenever warranted by the patient's condition, in unusual cases except in emergencies, or when otherwise required by Rules and policies.

2.8.13 Discharge such Medical Staff, department, committee and service functions for which he or she is responsible by appointment, election or otherwise.

2.8.14 Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be reasonably required from time to time.

2.8.15 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care or review of the care of specific patients, or payment for the care of specific patients.

2.8.16 Communicate with appropriate department officers and/or Medical Staff officers when he or she obtains credible information indicating that a fellow Medical Staff member or AHP may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

2.8.17 Accept responsibility for participating in Medical Staff proctoring in accordance with applicable Bylaws, Rules and policies.

2.8.18 Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the practitioner's specialty.

2.8.19 Participate in emergency service coverage or on-call coverage and consultation panels required by the Rules and policies.

2.8.20 Cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially compensated patient care obligations.

2.8.21 Promptly inform the Medical Staff of any significant changes in the information required on appointment and reappointment; the member's qualifications as set forth in these Bylaws; or any other issues that may materially affect the member's ability to meet the requirements for medical staff membership or otherwise render appropriate patient care.

2.8.22 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee.

Article 3
CATEGORIES OF THE MEDICAL STAFF

3.1 Categories. The Medical Staff shall consist of the following categories: Active Staff; Consulting Staff; Courtesy Staff; Honorary and Retired Staff.

3.2 Assignment and Transfer in Staff Category.

1. The Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined below. Active Staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any member who has failed to have any activity. A Courtesy Staff member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee is responsible for reviewing, approving or disapproving assignments and transfers. The transfers shall be done at the time of reappointment.

2. The Board of Trustees, on the recommendation of the Medical Executive Committee, may rescind an automatic transfer, but only if the practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements. Changes in Medical Staff category shall not be grounds for a hearing under Article 13 unless they adversely affect the member's privileges.

3.3 Provisional Medical Staff.

All initial appointments to the Medical Staff are considered *provisional*. Each provisional appointee will be observed and evaluated by a physician or physicians appointed by the Chairman of Medicine or Chairman of Surgery to determine his/her eligibility for membership in the staff category requested by the practitioner and for exercising the clinical privileges provisionally granted. The provisional appointee has the prerogatives and responsibilities of the staff category he/she has requested but shall not have the right to vote at Medical Staff meetings and may not hold office on the Medical Staff.

At the end of a 12 month provisional period, the Medical Executive Committee will determine if the appointee is to be advanced to the requested staff category with all the prerogatives pertaining to that category. Provisional status may not be renewed for more than a total of twelve months. If the provisional appointee fails within that period to furnish the certifications as stated above, his/her Medical Staff membership and applicable clinic privileges shall automatically terminate. The appointee so affected shall be given special notice of such termination and shall be entitled to procedural rights as detailed in Article 13.

All initial appointments shall remain provisional until the appointee has furnished, through appropriate medical staff channels, to the Chief Executive Officer and to the Authority Board:

- A statement signed by the Chief of Staff that the appointee meets all of the qualifications, has discharged all the responsibilities, and has not exceeded or abused the prerogatives of the Staff category to which he/she was provisionally appointed.

- A statement signed by the Chief of Staff that the appointee has satisfactorily demonstrated his/her ability to exercise the clinical privileges provisionally granted to him/her.

3.4 Active Medical Staff.

3.4.1 Qualifications. Active Staff consists of practitioners who are regularly involved in caring for patients at the Hospital or demonstrate, by way of other substantial involvement in Medical Staff or Hospital activities, a genuine concern and interest in the Hospital. Regular involvement in patient care shall mean admitting inpatients or outpatients or referring or consulting on at least *[eight]* cases each calendar year. Active Staff members must:

1. Continuously satisfy the qualifications for Medical Staff membership set forth in Article 2.

2. Apply for membership and for reappointment.

3.4.2 Prerogatives. Active Staff members may:

1. Admit patients consistent with approved privileges.

2. Exercise those clinical privileges that have been approved.

3. Vote on any Medical Staff matter including Bylaws amendments, officer selection and other matters presented at any general or special Medical Staff meetings and matters presented at department meetings.

4. Hold office in the Medical Staff and in the department to which he or she is assigned.

5. Serve on committees and vote on committee matters.

3.4.3 Responsibilities In addition to the basic responsibilities set forth in Article 2, Active Staff members must:

1. Contribute to and participate equitably in staff functions, at the request of the department chair or a Medical Staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring of other practitioners; and fulfilling such other Medical Staff functions as may reasonably be required.

2. Consult with other members consistent with his or her delineated privileges.

3. Serve on the on-call roster and accept responsibility for providing care to any patient requiring on-call coverage in his or her specialty, in accordance with applicable Bylaws, Rules and policies.

4. Attend at least the minimum number of Medical Staff and department meetings as specified in the Bylaws or Rules.

3.5 Consulting Staff.

3.5.1 Qualifications. Consulting Staff consists of practitioners who possess ability and knowledge that enable them to provide valuable assistance in difficult cases, and are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence. Consulting Staff must:

1. Continuously satisfy the qualifications for Medical Staff membership set forth in Article 2.

2. Apply for membership and for reappointment.

3.5.2 Prerogatives. Consulting Staff members may:

1. Consult with Medical Staff members within their area of competence, but Consulting Staff members may not admit patients.

2. Exercise those clinical privileges that have been approved.

3. Attend meetings of the Medical Staff, but shall have no right to vote at such meetings and may not hold office on the Medical Staff.

4. Serve on committees and vote on committee matters, but not serve as committee chairs.

3.5.3 Responsibilities. In addition to the basic responsibilities set forth in Article 2, Consulting Staff members must:

1. Contribute to and participate equitably in Medical Staff functions, at the request of a department chair or other Medical Staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on Hospital and Medical

Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring of other practitioners; and fulfilling such other functions as may reasonably be required.

2. Consult with other members consistent with his or her delineated privileges.

3.6 Courtesy Staff.

3.6.1 Qualifications. Courtesy Staff consists of practitioners who admit, refer or otherwise provide services for at least three but no more than eight patients at the Hospital during each calendar year. Courtesy Staff members must:

1. Continuously satisfy the qualifications for Medical Staff membership set forth in Article 2.

2. Apply for membership and for reappointment.

3. Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested clinical privileges.

3.6.2 Prerogatives. Courtesy Staff members may:

1. Admit patients consistent with approved privileges.

2. Exercise those clinical privileges that have been approved.

3. Attend meetings of the Medical Staff, but shall have no right to vote at such meetings and may not hold office on the Medical Staff.

4. Serve on committees and vote on committee matters, but may not serve as a committee chair.

3.6.3 Responsibilities. In addition to the basic responsibilities set forth in Article 2, Courtesy Staff members must:

1. Contribute to and participate equitably in Medical Staff functions, at the request of the department chair or other Medical Staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring of other practitioners; and fulfilling such other functions as may reasonably be required.

2. Consult with other members consistent with his or her delineated privileges.

3. Serve on the on-call roster and accept responsibility for providing care to any patient requiring on-call coverage in his or her specialty, in accordance with applicable Bylaws, Rules and policies.

3.7 Honorary and Retired Staff.

3.7.1 Qualifications. Honorary and Retired Staff consists of practitioners who are deemed deserving of membership by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the Hospital, and members who were in

good standing when they retired. Honorary and Retired Staff are not required to apply for appointment or reappointment or have liability insurance.

3.7.2 Prerogatives. Honorary and Retired Staff members are not eligible to admit patients or exercise clinical privileges at the Hospital. However, Honorary and Retired Staff members may:

1. Attend meetings of the Medical Staff, but shall have no right to vote at such meetings and may not hold office on the Medical Staff.

2. Serve on committees and vote on committee matters, but may not serve as a committee chair.

3.8 Telemedicine Staff.

3.8.1 Qualifications. Telemedicine Staff shall consist of practitioners who provide diagnostic or treatment services to Hospital patients via telemedicine devices. Telemedicine devices include interactive (involving a real time [synchronous] or near real time [asynchronous] two-way transfer of medical data and information) audio, video, or data communications between practitioner and patient. Telemedicine devices do not include telephone or electronic mail communications between practitioner and patient. Telemedicine Staff members must:

1. Privileging will be done through a distant site agreement.

3.8.2 Prerogatives. Telemedicine Staff members may:

1. Admit patients consistent with approved privileges.

2. Exercise those clinical privileges that have been approved.

3. Attend meetings of the Medical Staff, but shall have no right to vote at such meetings and may not hold office on the Medical Staff.

4. Serve on committees and vote on committee matters, but may not serve as committee chair.

3.8.3 Responsibilities. In addition to the basic responsibilities set forth in Article 2, Telemedicine Staff members must:

1. Contribute to and participate equitably in Medical Staff functions, at the request of the department chair or a Medical Staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring of other practitioners; and fulfilling such other functions as may reasonably be required.

2. Consult with other members consistent with his or her delineated privileges.

3.9 General Exceptions to Prerogatives for Limited License Members. Regardless of the category of membership in the Medical Staff, limited license members:

3.9.1 May not hold any general Medical Staff office.

3.9.2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

3.9.3 Shall exercise privileges only within the scope of their licensure and as limited by the Bylaws and Rules.

3.10 Affiliate Staff.

3.10.1 Qualifications. Affiliate Staff consists of medical staff who do not have patient activity at Three Rivers Health, but who are providing care in the outlying clinics run by Three Rivers Health and must be credentialed and re-credentialed by Three Rivers Health.

1. Continuously satisfy the qualifications for Medical Staff membership set forth in article 2.
2. Do not admit or treat patients at Three Rivers Health, nor have ongoing admitting privileges.
3. Apply for membership and reappointment
4. Prior to reappointment, provide evidence of current clinical performance at the clinic where they practice in such a form as the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested clinical privileges.

3.10.2 Prerogatives. Affiliate Staff members may:

1. Exercise those clinical privileges that have been approved
2. Vote on any Medical Staff matter including Bylaw amendments, officer selection and other matters presented at any general or special Medical Staff meeting and matters presented at department meetings.
3. Hold office in the Medical Staff and in the department to which he or she is assigned.
4. Serve on committees and vote on committee matters.

3.10.3 Responsibilities. In addition to the basic responsibilities set forth in Article 2, Affiliate Staff members must:

1. Contribute to and participate equitably in Medical Staff functions, at the request of a department chair or other Medical Staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring of other practitioners; and fulfilling such other functions as may reasonably be required.
2. Are required to meet the attendance requirements of Article 10.6
3. Must pay applicant fees as well as Medical Staff dues.
4. Consult with other members consistent with his or her delineated privileges.

Article 4
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 General. The Active Staff or a committee thereof shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category pursuant to these Bylaws and the Rules. The Active Staff shall also perform this function for practitioners who seek temporary privileges and for AHPs. The Active Staff shall investigate each applicant before recommending action to the Board of Trustees. The Board of Trustees shall have ultimate authority to

grant or deny membership and privileges or place conditions thereon. These functions may be delegated to the Chief of Staff and CEO with respect to requests for temporary privileges. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules as they exist and as they may be modified from time to time.

4.2 Applicant's Burden. An applicant for appointment, reappointment, advancement, transfer and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges; resolving any reasonable doubts about these matters; and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a medical or psychological examination as provided in the Bylaws or Rules.

4.3 Application for Initial Appointment and Reappointment. An applicant for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigation of and/or action on the application. The information shall be verified and evaluated by the Medical Staff or its delegee using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Board of Trustees whether to appoint, reappoint or grant specific privileges.

4.3.1 Content. The application form shall include:

1. Acknowledgment and Agreement. A statement that the applicant has received and read the current Bylaws, Rules and Regulations of the Medical Staff, the current Hospital Bylaws and Policies and that he/she agrees:

1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

2) to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted membership and/or clinical privileges.

2. Qualifications. Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications, and of any additional qualifications specified in these Bylaws for the particular staff category to which the applicant requests appointment. Applicant must sign attestation of board certification or present evidence of board eligibility within five years from date of appointment.

3. Requests. Specific requests stating the staff category and specific clinical privileges for which the applicant whishes to be considered.

4. References. The names of practitioners who have worked with the applicant and personally observed his/her professional performance and who will provide truthful references as to the applicant's education, experience and clinical ability, ethical character, and ability to work with others. Three professional peer references are required.

5. Professional Sanctions. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced to not renewed at any other

hospital or health care institution, and as to whether any of the following have ever been suspended, revoked or denied:

1) Membership/fellowship in local, state or national professional organizations

2) specialty board certifications

3) license to practice any profession in any jurisdiction

4) Drug Enforcement Agency (DEA) numbers. If any such actions were ever taken, the particulars thereof shall be included.

6. Professional Liability Insurance. Information as to whether the applicant has currently in force professional liability insurance coverage in amounts deemed adequate by the Board of Trustees for the protection of the Hospital considering his/her experience, the scope of his/her clinical privileges and any medical specialty he/she may practice.

7. Information Malpractice Experience. It is mandatory that the applicant furnish all information concerning malpractice cases against him/her, either pending, settled, or filed.

8. Notification of Release and Immunity Provisions. Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity, and release provisions of Article 11.

9. Administrative Remedies. A statement whereby the practitioner agrees that, when an adverse ruling is made with respect to his/her Staff Membership, Staff Status, in and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

10. Statement of Health. A statement indicating the date of the practitioner's last physical examination, the name of the examiner, any significant findings, and a listing of hospital care received in the past five years, the date of the last TB skin test within the prior 12 months or chest x-ray within past three years (if the practitioner has received TB vaccination or has had a positive TB skin test).

12. Challenges to License or Voluntary Relinquishment. Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or voluntary relinquishment of licensure or registration must be so stated by the applicant.

13. Curriculum Vitae. Information must include complete education, board certification, work history and all current and past hospital affiliations.

14. Application and authorization for Background Request. Applicant must complete application and sign release from liability and authorization to obtain information for medical staff application.

15. Termination of Membership of Privileges. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital must be so stated by the applicant.

16. Sick, Disabled and/or Impaired Physician. Applicant will be given a brochure describing the Three Rivers Health System, Inc medical staff program for the "Sick, Disabled and/or Impaired physician".

17. Collection of data. Three Rivers Health System, Inc may use any reasonable and usual means available to collect the above information including but not limited to the National Practitioner Data Bank, AMA, AOIA, DEA, and licensing boards. An independent security firm may be utilized to obtain background information on the practitioner.

1) Telemedicine: If the practitioner is requesting telemedicine privileges, Three Rivers Health may utilize credentialing and privileging information from the distal site providing practitioner services.

4.3.2 Basis for Appointment. Recommendations for appointment to the Medical Staff and for granting privileges shall be based upon the applicant's training, experience and professional performance at this Hospital and in other settings; whether the applicant meets the qualifications and can carry out all of the responsibilities specified in the Hospital and Medical Staff Bylaws, rules and policies; the applicant's physical and mental capabilities; and upon the Hospital's best interests, patient care needs, and ability to provide adequate support services and facilities for the practitioner.

4.3.3 Basis for Reappointment. Reappointments must be made at least every two years. Reappointment recommendations (including privilege recommendations) shall be based upon the member's professional performance at this Hospital and in other settings; whether the member has met all of the qualifications and carried out all of the responsibilities set forth in the Medical Staff and Hospital Bylaws, rules and policies; the member's physical and mental capabilities; and upon the Hospital's best interests, patient care needs, and ability to provide adequate support services, facilities, and equipment for the practitioner. Where applicable, the results of specific peer review activities shall also be considered.

4.3.4 Extension of Appointment. If the reappointment application has not been fully processed before the member's appointment expires, the member's membership status and privileges shall be automatically suspended until the review is completed, unless: (i) good cause exists for the care of a specific patient or patients and no other health professional currently privileged possesses the necessary skills and is available to provide care to the specific patient(s), in which case the member's privileges may be temporarily extended while his or her full credentials information is verified and approved; or (ii) the delay is due to the member's failure to timely return the reappointment application form or provide other documentation or cooperation, in which case the appointment shall terminate as provided in the next section. An extension of an appointment does not create a vested right for the member to be reappointed.

4.3.5 Failure to File Reappointment Application. Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting and other privileges and prerogatives at the end of the current Medical Staff appointment unless otherwise extended by the Medical Executive Committee with the approval of the Board of Trustees. If the member fails to submit a completed application for reappointment within the time specified in the Bylaws or Rules, the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the member shall not be entitled to the procedural rights described in Article 13.

4.4 Leave of Absence. Members may request a leave of absence, which must be approved by the Medical Executive Committee and cannot exceed two years. Reinstatement at the end of the **leave must** be approved in accordance with the standards and procedures set forth in the Rules for reappointment review. The member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive.

4.5 Waiting Period after Adverse Action.

4.5.1 Who Is Affected.

1. A waiting period of 24 months shall apply to the following practitioners:

1) An applicant who (i) has received a final adverse decision concerning appointment or (ii) withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Board of Trustees;

2) A former member who has (i) received a final adverse decision which resulted in termination of membership and/or privileges, or (ii) resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or Board of Trustees issuing an adverse recommendation; or

3) A member who has received a final adverse decision resulting in (i) termination or restriction of his or her privileges or (ii) denial of his or her request for additional privileges.

2. For practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Board of Trustees, to waive the 24-month period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.

3. An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move) or to maintain professional liability insurance (which can be cured by obtaining the insurance).

4.5.2 Date When the Action Becomes Final. The action is considered final on the latest date on which the application or request was withdrawn; a member's resignation became effective; or upon completion of (i) all Medical Staff and Hospital hearings and appellate reviews, and (ii) all judicial proceedings pertinent to the action served within two years after the completion of the Hospital proceedings.

4.5.3 Effect of the Waiting Period. Except as otherwise allowed per Section 4.5.1(b), practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the practitioner may reapply. The application will be processed like an initial application or request, plus the practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.6 Confidentiality; Impartiality. To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and Rules for processing applications for appointment and reappointment.

Article 5
PRIVILEGES

5.1 Exercise of Privileges. Except as otherwise provided in these Bylaws or Rules, every practitioner or AHP providing direct clinical services at this Hospital shall be entitled to exercise only those privileges specifically granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this Hospital or to patients of another facility that this Hospital is assisting via telemedicine technology) must apply for and be granted procedure-specific telemedicine privileges. Additionally, practitioners who are not otherwise members of this Hospital's Medical Staff must apply for and be granted membership and privileges as part of the Telemedicine Staff in order to provide services to patients of this Hospital.

5.2 Delineation of Privileges in General.

5.2.1 Requests. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. Each department will be responsible for developing criteria for granting privileges and including those criteria in the department's rules.

5.2.2 Bases for Privilege Determinations. Requests for privileges shall be evaluated on the basis of the practitioner's education, training, and experience; demonstrated professional competence and judgment; clinical performance; the documented results of patient care and other quality improvement review and monitoring; performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge; compliance with any specific criteria applicable to the privileges; and the Hospital's needs and capabilities for providing qualified support staff and equipment. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, including but not limited to other institutions and health care settings where a practitioner exercises privileges.

5.2.2.1 Special Conditions for Podiatric Privileges. Requests for clinical privileges from Podiatrists shall be processed in the manner specified above. Surgical procedures performed by Podiatrists shall be under the supervision of the Chief of the Surgery Division. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. The Medical Executive Committee may designate Podiatrists, having completed an additional surgical residency, who may perform the physical examinations and prepare the histories for their own patients. A Practitioner member of the staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and, unless the Podiatrist has been granted privileges to perform the physical examination for his/her own patient, this designated Practitioner member shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. The responsible Practitioner member of the staff shall be identified prior to admission of the patient for surgery to be performed by a Podiatrist member of the staff.

5.3 Conditions for Privileges of Limited License Practitioners. The procedure for granting privileges set forth above shall apply to limited license practitioners, including dentists, oral surgeons, clinical psychologists and podiatrists. Limited license practitioners who have received appropriate privileges may perform the following services:

5.3.1 Admissions. Limited license practitioners may admit patients only if a physician member of the Active Staff assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice. The limited license practitioner who admits the patient shall have

the sole responsibility to arrange for a physician member of the Active Staff to assume responsibility for the patient. The limited license member may initiate admission, but the admission is not complete until a history and physical is performed in accordance with applicable Rules and policies.

5.3.2 Medical Appraisal. All patients admitted for care in the Hospital by a limited license practitioner shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

5.3.3 Surgery and High Risk Interventions. Surgical procedures performed by limited license practitioners shall be under the overall supervision of the chair of the designated department or the chair's designee. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.4 Temporary Privileges.

5.4.1 Circumstances Temporary privileges may be granted after appropriate application:

1. For 60-day periods, subject to renewal during the pendency of an application;

2. For practitioners who will serve as locum tenens for a Medical Staff member for up to 60 days at a time, subject to renewal to a total of 120 days in any consecutive six month period; or

3. As otherwise necessary to fulfill an important patient care need.

5.4.2 Application and Review. Temporary privileges may be granted after the practitioner completes the application procedure and the Medical Staff completes the application review process described in the Rules. Temporary privileges may be granted by the CEO (or his or her designee) on the recommendation of the Chief of Staff or the department chair where the privileges will be exercised, or either's designee.

1. There is no right to temporary privileges. Temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting practitioner's or AHP's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner or AHP has demonstrated compliance with the Rules. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.

2. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

5.4.3 General Conditions and Termination.

1. Practitioners granted temporary privileges shall be subject to the proctoring and supervision specified in the Bylaws and Rules.

2. Temporary privileges shall automatically terminate at the end of the designated period unless earlier terminated or affirmatively renewed as provided in the Bylaws or Rules.

3. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible department chair, or the CEO after conferring with the Chief of Staff or the responsible department chair. A person shall be entitled to the procedural rights described in Article 13 only if a request for temporary privileges is refused based upon or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.

4. Whenever temporary privileges are terminated, the appropriate department chair or, in the chair's absence, the Chief of Staff shall assign a member to assume responsibility for the care of the practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.

5. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.

5.5 Emergency Privileges. A medical emergency is an injury or illness that is acute and poses an immediate risk to a person's life or long term health. In the event of an emergency, any member of the Medical Staff or credentialed AHP shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or AHP shall promptly yield such care to a qualified member when one becomes available.

5.6 Transport and Organ Harvest Teams. Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the Hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with the Hospital.

5.7 Proctoring.

5.7.1 General Proctoring Requirements.

1. Except as otherwise determined by the Medical Executive Committee and Board of Trustees, all initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of proctoring in accordance with standards and procedures set forth in the Bylaws and Rules. In addition, members may be required to be proctored as a condition of renewal of privileges (e.g., when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area). Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information gathering measure. It should be imposed only for such period or number of cases as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article 13 unless the proctoring becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

2. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.

5.7.2 Completion of Proctoring. Proctoring shall be deemed successfully completed when the practitioner completes the required number of proctored cases within the time frame established in the Bylaws, Rules, or as required by a condition imposed by the Medical Executive Committee or Board

of Trustees, and the practitioner's professional performance in the cases met the standard of care of the Hospital.

5.7.3 Effect of Failure to Complete Proctoring.

1. **Failure to Complete Necessary Volume:** Any member who fails to complete the required number of proctored cases within the time frame established by the Bylaws, Rules, or imposed conditions shall be deemed to have voluntarily withdrawn his or her request for membership or the relevant privileges, and he or she shall not be afforded the procedural rights described in Article 13. However, the Medical Executive Committee has the discretion to extend the time for completion of proctoring in appropriate cases. The inability to obtain such an extension shall not give rise to procedural rights described in Article 13.

2. **Failure to Satisfactorily Complete Proctoring:** If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, the practitioner's membership may be terminated or the relevant privileges may be revoked, and he or she shall be afforded the procedural rights described in Article 13.

Article 6
ALLIED HEALTH PROFESSIONALS

6.1 Qualifications of Allied Health Professionals. Allied health professionals (AHPs) are not eligible for medical staff membership. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the Board of Trustees, after consulting with the Medical Executive Committee, has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Bylaws and Rules.

6.2 Categories. The Board of Trustees shall determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise privileges in the Hospital.

1. **Unsupervised (Psychology)**
2. **Supervised:**
   a. Direct
   b. Indirect
   Requirement:
   a. Annual Competency
   b. Bi-Annual Quality Review every two years.

6.3 Privileges and Responsibilities.

6.3.1 AHPs may exercise only those privileges specifically granted them by the Board of Trustees. The range of privileges for which each AHP may apply and any special limitations or conditions to the exercise of such privileges shall be based on recommendations of the Medical Executive Committee and, as applicable, the relevant department.

6.3.2 An AHP must apply and qualify for practice privileges as set forth in the Bylaws and Rules. Practitioners who desire to supervise or direct AHPs providing dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for practitioners, unless otherwise specified in the Rules.

6.3.3 Each AHP shall be assigned to the department(s) appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or Rules, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.3.4 Patients being treated by AHPs and other non-physician practitioners shall be under the general care of a physician.

6.4 Procedural Rights of Allied Health Professionals.

6.4.1 Fair Hearing and Appeal Process. If an AHP is subject to an adverse decision affecting his or her clinical privileges, the AHP shall be entitled to the fair hearing and appeal process applicable to AHPs as set forth in the Rules applicable to AHPs. They are not entitled to the procedural rights described in Article 13 of these Bylaws or its Rules.

6.4.2 Automatic Termination. Notwithstanding the provisions of Section 6.4.1, an AHP's privileges shall automatically terminate without review in the event:

a. Practitioner supervision of the AHP is required by applicable laws or Rules, and the Medical Staff membership of the supervising practitioner is terminated for any reasons; the supervising practitioner no longer agrees to act as the supervising practitioner for any reason; or the relationship between the AHP and the supervising practitioner is otherwise terminated regardless of the reason therefore; or

b. The AHP's certification or license expires, is revoked, or is suspended.

6.4.3 Review of Category Decisions. The rights afforded by this Section or the Rules shall not apply to any decision regarding whether a category of AHP shall be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions may be submitted for consideration to the Board of Trustees, which has the discretion to decline to review the request or to review it using any procedure the Board of Trustees deems appropriate.

6.5 Prerogatives. The prerogatives which may be extended to an AHP shall be defined in the Rules and/or Hospital policies. Such prerogatives may include:

6.5.1 Provision of specified patient care services under the supervision or direction of a Medical Staff member and be consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification. A physician assistant may not provide professional services to a patient whose problem or condition is outside the scope of privileges granted to the supervising physician.

6.5.2 . Service on Hospital, Medical Staff, and department committees.

6.5.3 Attendance at meetings of the department to which the AHP is assigned as permitted by the department rules and attendance at Hospital education programs in the AHP's field of practice.

6.6 Responsibilities. Each AHP shall:

6.6.1 Meet those responsibilities required by the Rules as specified for practitioners in Section 2.8, Basic Responsibilities of Medical Staff Membership, as modified to reflect the more limited practice of the AHP.

6.6.2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services.

6.6.3 Participate in peer review, quality improvement and in discharging such other functions as may be required from time to time.

Article 7
MEDICAL STAFF OFFICERS

7.1 General Provisions.

7.1.1 Identification. There general officers of the Medical Staff shall be the Chief of Staff and Vice Chief of Staff. In addition, the Medical Staff's department officers and committee chairs shall be deemed Medical Staff officers.

7.1.2 Qualifications. Each Medical Staff officer shall:

1. Be a member of the Active Staff and remain in good standing as an Active Staff member while in office;

2. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

3. Understand and be willing to work toward attaining the Hospital's lawful and reasonable policies and requirements;

4. Have administrative ability as applicable to the respective office;

5. Be able to work with and motivate others to achieve the objectives of the Medical Staff and Hospital;

6. Demonstrate clinical competence in his or her field of practice; and

7. Not have any significant conflict of interest.

7.1.3 Disclosure of Conflict of Interest. All nominees for election or appointees to Medical Staff offices shall, at least 20 days prior to the date of election or within 20 days of appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee/appointee and the Board of Trustees. The Board of Trustees may remove a nominee from the ballot or remove an appointee from office if it determines that the conflict of interest could significantly and adversely affect the Hospital. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

7.2 Method of Selection -- General Officers.

7.2.1 Nomination. The Medical Staff members who are eligible to vote may nominate candidates for the offices of Chief of Staff and Vice Chief of Staff. The nominees must satisfy the qualifications for office set forth in these Bylaws. Such nominations must be received by the Chief of Staff at least 30 days prior to the scheduled elections.

7.2.2 Election. The election shall take place annually in conjunction with a general Medical Staff meeting. The election may be by secret written ballot, and the outcome shall be determined by a majority of the votes cast.

7.2.3 Term of Office. The term of office for the Chief of Staff and Vice Chief of Staff shall be two years. The new officers shall take office on the first day of the month following the election.

7.3 Recall of Officers. The Chief of Staff or Vice Chief of Staff may be recalled from office for any valid cause, including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of the Chief of Staff or Vice Chief of Staff may be initiated by the Medical Executive Committee or by a petition signed by at least one-third (1/3) of the Medical Staff members eligible to vote for officers; but recall itself shall require a two-thirds (2/3) vote of the Medical Executive Committee or two-thirds (2/3) vote of the Medical Staff members eligible to vote for general Medical Staff officers.

7.4 Filling Vacancies. Vacancies created by resignation, removal, disqualification, death or disability shall be filled as follows: A vacancy in the office of Chief of Staff shall be filled by the **Vice Chief** of Staff for the remainder of the two-year term. A vacancy in the office of Vice Chief of Staff shall be filled for the remainder of the original one-year term by special election held in general accordance with Section 7.2.

7.5 Duties of Officers.

7.5.1 Chief of Staff. The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

1. Enforcing the Medical Staff Bylaws and Rules, promoting quality care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

2. Calling, presiding at, and supervising the preparation of the agenda of all meetings of the Medical Executive Committee and general Medical Staff;

3. Serving as chair of the Medical Executive Committee;

4. Serving as an ex officio member of all other Medical Staff Committees except hearing committees;

5. Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees, and designating the chairpersons of these committees;

6. Being a spokesperson for the Medical Staff in external professional and public relations;

7. Serving on liaison committees with the Board of Trustees and administration, as well as outside licensing or accreditation agencies;

8. Regular reporting to the Board of Trustees on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Board of Trustees;

9. In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee; and

10. Performing such other functions as may be assigned to him or her by these Bylaws, Rules, the Medical Staff or the Medical Executive Committee.

7.5.2 Vice Chief of Staff. The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, Rules, or the Medical Executive Committee.

7.5.3 Sec/Treas. The Sec/Treas shall assume the supervision of the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees.

Article 8
COMMITTEES

8.1 General.

8.1.1 Designation. The Medical Executive Committee shall be a standing committee of the Medical Staff. The Medical Staff, with Board of Trustees approval, may establish such other standing committees as it deems necessary to carry out its functions. In addition, the Medical Executive Committee or departments may establish special or ad hoc committees to perform specified tasks. Any committee, whether standing, special or ad hoc, that is carrying out a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

8.1.2 Appointment of Members.

1. Unless otherwise specified by the Bylaws or Rules, the chair and members of a committee shall be appointed by and may be removed by the Chief of Staff in consultation with and as approved by the Medical Executive Committee.

2. Unless otherwise specified by the Bylaws or Rules and as necessary to carry out their functions, Medical Staff committees may include any category of Medical Staff members; AHPs; representatives from Hospital departments (e.g., administration, nursing services, or health information services); representatives of the community; and persons with special expertise. Each Medical Staff member who serves on a committee has voting privileges unless the Bylaws or Rules establishing such committee provides otherwise.

3. A committee chair may appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

8.1.3 Representation on Hospital Committees and Participation in Hospital Deliberations. The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant

safety by providing Medical Staff representation on Hospital committees established to perform such functions.

8.1.4 Ex Officio Members. The Chief of Staff and the CEO, or their respective designees, are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

8.1.5 Action through Subcommittees. Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the CEO regarding Hospital staff.

8.1.6 Terms and Removal of Committee Members. Unless otherwise specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period or until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by the department chair may be removed by a majority vote of his or her department committee or the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

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

8.1.8 Conduct and Records of Meetings. Committees shall meet as often as necessary, but at least twice annually, to assure implementation of required functions of the Hospital. Minutes of all meetings shall be maintained.

8.1.9 Attendance of Nonmembers. Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee’s meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the member’s attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

8.1.10 Accountability. All committees shall be accountable to the Medical Executive Committee.

8.2 Medical Executive Committee.

8.2.1 Composition. The Medical Executive Committee shall be composed of the Chief of Staff, the Vice Chief of Staff, Sec/Treas, Medical Staff Department Chairman, and two appointed members. The Chief of Staff shall chair the Medical Executive Committee.

8.2.2 Duties. With the assistance of the Chief of Staff, the Medical Executive Committee shall perform the duties listed below.

1. Supervise the performance of all Medical Staff functions, which shall include:

1) requiring regular reports and recommendations from the departments, committees and officers of the Medical Staff concerning discharge of assigned functions;

2) issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

3) following up to assure implementation of all directives.

2. Coordinate the activities of the committees and departments.

3. Make recommendations to the Board of Trustees regarding criteria for Medical Staff appointment, reappointment and privileges.

4. Make recommendations to the Board of Trustees regarding all applications for Medical Staff appointment, reappointment and privileges.

5. When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members.

6. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

1) the Medical Staff Bylaws, Rules and policies;

2) the Hospital's Bylaws, Rules and policies;

3) state and federal laws and regulations; and

4) Any applicable accreditation requirements.

7. Oversee the development of Medical Staff policies, approve or disapprove all such policies, and oversee the implementation of all such policies.

8. Implement, as it relates to the Medical Staff, the approved policies of the Hospital.

9. With the department chairs as applicable, set departmental objectives for establishing, maintaining and enforcing professional standards within the Hospital and for the continuing improvement of the quality of care rendered in the Hospital, and assist in developing programs to achieve these objectives.

10. Regularly report to the Board of Trustees through the Chief of Staff and the CEO on at least the following:

1) the outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Board of Trustees that quality of care is consistent with professional standards; and

2) the general status of any Medical Staff disciplinary or corrective actions in progress.

11. Make recommendations to the Board of Trustees regarding the structure of the Medical Staff; the mechanism used to review credentials and to delineate individual privileges; the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities; the mechanism by which membership

on the Medical Staff may be terminated; and the mechanism for hearing procedures. This responsibility may be satisfied by way of the Bylaws and Rules addressing these issues.

12. Review and make recommendations to the CEO regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

13. Establish, as necessary, such special and ad hoc committees that will fulfill particular functions and will report directly to the Medical Executive Committee.

14. Establish the date, place, time and program of the regular meetings of the Medical Staff.

8.2.3 Meetings. The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least 10 times during the calendar year. Minutes of meetings shall be kept.

Article 9
DEPARTMENTS

9.1 Organization of Departments. The Medical Staff, subject to Board of Trustees approval, may organize and establish departments to assist the Medical Staff in fulfilling its purpose. The structure, officers, functions, and responsibilities of such departments may be set forth in the Rules.

9.2 The Medical Staff shall be organized into two departments: Medicine and Surgery.

9.3 Each department shall have a chairperson with overall responsibility for the supervision and satisfactory discharge of assigned functions of the department.

Article 10
MEETINGS

10.1 Medical Staff Meetings.

10.1.1 General Medical Staff Meetings. The Medical Staff shall meet in general Medical Staff meetings quarterly to assure implementation of the required functions of the Medical Staff. The date, place and time of the general meetings shall be determined by the Chief of Staff. Notice shall be given to the members at least thirty (30) days prior to regular meetings, provided that personal attendance at a meeting shall constitute a waiver of notice of such meeting. The agenda for the general meetings shall include administrative reports from the Chief of Staff and committees; action necessary to assure the implementation of the required functions of the Medical Staff; the election of officers when required by the Bylaws or Rules; and other matters believed to be of interest and value to the membership.

10.1.2 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, Board of Trustees, or upon the written request of one-third (1/3) of the voting members. The person calling or requesting the special meeting shall state in writing the purpose of such meeting. The meeting shall be scheduled by the Medical Executive Committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members which include the stated purpose of the meeting.

10.2 Committee Meetings. Committees shall meet as often as necessary, but at least twice annually, to assure implementation of their required functions. The frequency of committee meetings may be set forth in the Rules.

10.3 Quorum.

10.3.1 Medical Staff Meetings. The presence of one-half (1/2) of the voting Medical Staff members at any regular or special meeting shall constitute a quorum.

10.3.2 Committee Meetings. The presence of one-half (1/2) of the voting members shall be required for Medical Executive Committee meetings. The requirement for a quorum for other committees shall be as stated in the Rules or approved by the Medical Executive Committee.

10.4 Manner of Action. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting if it is acknowledged in writing setting forth the action so taken which is signed by a majority of the committee members.

10.5 Minutes. Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded to the Medical Executive Committee or other designated committee and Board of Trustees. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by state and federal law.

10.6 Attendance Requirements.

10.6.1 Regular Attendance Requirements. Each member of the Active or Courtesy Medical Staff is required to attend at least one-half (1/2) of all general Medical Staff meetings during the calendar year. Each member of the Allied Health Professional Staff that is hospital based is required to attend at least one-half (1/2) of all general Medical Staff meetings during the calendar year.

10.6.2 Failure to Meet Attendance Requirements. Practitioners who have not met meeting attendance requirements may have their Medical Staff membership and privileges terminated or changed as determined appropriate by the Board of Trustees. Such practitioners shall not be entitled to the fair hearing process set forth in Article 13.

10.6.3 Special Appearance. A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the practitioner advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, written notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given written notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The practitioner shall be entitled to the procedural rights described in Article 13.

10.7 Conduct of Meetings. Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

Article 11
CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 General. Medical Staff, department, or committee minutes, files and records (including information regarding any member or applicant to this Medical Staff) shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee and the CEO.

11.2 Breach of Confidentiality. Inasmuch as effective credentialing, quality improvement, peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of the Medical Staff, departments, or committees, except in conjunction with another health facility's professional society's or licensing authority's peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 Immunity and Release.

11.3.1 Immunity from Liability for Providing Information or Taking Action. Each representative of the Medical Staff and Hospital and all third parties shall, to the maximum extent allowed by law, be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, Hospital or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this Hospital or by reason of otherwise participating in Medical Staff or Hospital credentialing, quality improvement or peer review activities.

11.3.2 Activities and Information Covered. The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment, privileges, or specified services;
2. Periodic reappraisals for reappointment, privileges, or specified services;
3. Corrective action;
4. Hearings and appellate reviews;
5. Quality improvement review, including patient care audit;

6. Peer review;

7. Utilization reviews;

8. Morbidity and mortality conferences; and

9. Other Hospital, department or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

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

11.5 Cumulative Effect. Provisions in these Bylaws, Rules and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

Article 12
PEER REVIEW AND CORRECTIVE ACTION

12.1 Participation in Peer Review Activities. Medical Staff members are required to actively and cooperatively participate in Medical Staff committees and other peer review activities to review the professional practices of members of the Medical Staff, AHPs or other health care providers affiliated with the Hospital for the purpose of reducing morbidity and mortality; assessing and improving patient care; and improving the functions of the Hospital.

12.2 Peer Review and Corrective Action Process. Who is subject to this Article 12. All physicians who have privileges at Three Rivers Health System, Inc are subject to this Article 12. The word "practitioner" as it is used in this article means all physicians who have privileges at Three Rivers Health System, Inc.

12.2.1 Who May Initiate Proceedings: A proceeding for corrective action may be initiated by any person or group of persons, including but not limited to an individual member of the Medical Staff, The CEO, the Medical Executive Committee, The Medical Staff or the Governing Board.

12.2.2 How Proceedings Shall Be Initiated: A proceeding for corrective action shall be initiated by sending to the Chief of Staff, or Vice Chief of Staff if the Chief of Staff is not available, a written complaint, signed by the complaining person or group of persons. The written complaint shall be sent as just prescribed as soon as practicable after the event or events that give rise to the complaint. The Chief of Staff or Vice Chief of Staff shall send copies of the complaint to the CEO and the practitioner in question within two weeks of when the Chief of Staff or Vice Chief of Staff receives the complaint. The copy of the complaint to the practitioner in questions shall be sent by certified mail, return receipt requested. The Medical Executive Committee shall have the right to dismiss any complaint that it determines was not sent to the Chief of Staff or Vice Chief of Staff as prescribed above as soon as practicable after the event or events that give rise to the complaint.

12.2.3 How Proceedings Shall be Handled:

1. The Chief of Staff shall present the complaint to the Medical Executive Committee at its next meeting.

2. The Medical Executive Committee shall immediately initiate such investigation into the complaint and matters related to the complaint as it considers necessary and appropriate.

3. With a view to arriving at a well-founded recommendation as to whether any corrective action is appropriate with respect to the practitioner in question, and, if so, what.

4. The Medical Executive Committee shall have the right to appoint a special committee or committee to perform such studies or reviews and submit such reports as it may direct. The Medical executive Committee may, with prior approval of the Governing Board, engage a physician or physicians outside the Medical Center to perform such studies or reviews and submit such reports as it may direct.

5. The Medical Executive Committee shall have the right to dismiss any complaint that it determines is groundless on its face.

6. The Medical Executive Committee shall issue its recommendation after such investigation as it considers necessary and appropriate. The Chief of Staff shall send the recommendation to the practitioner in question, by certified mail, return receipt requested, with a copy of same to the CEO and the Chairperson of the Governing Board.

12.3 Formal Corrective Action. Formal corrective action may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the Hospital that is reasonably likely to be:

1. detrimental to patient safety or to the delivery of quality patient care within the hospital;

2. unethical;

3. below applicable professional standards;

4. contrary to the Medical Staff Bylaws or Rules;

5. disruptive of Medical Staff or Hospital operations; or

6. an improper use of hospital resources.

12.4 Summary Restriction or Suspension. Whenever a practitioner's conduct is such that a failure to take action may result in imminent danger to the health or welfare of any individual, the Chief of Staff, the Medical Executive Committee, the chair of the department in which the member holds privileges, or the CEO may summarily restrict or suspend the Medical Staff membership or privileges of such member.

12.5 Automatic Suspension or Limitation. In the following instances, the member's privileges or membership may be suspended or limited as described:

12.5.1 Licensure.

1. Revocation, Suspension or Expiration. Whenever a member's license or other legal credentials authorizing practice in this state is revoked, suspended or expired without an application pending for renewal, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective and throughout its term.

2. Restriction. Whenever a member's license or other legal credentials authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

3. **Probation.** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

12.5.2 Drug Enforcement Administration (DEA) Certificate.

1. **Revocation, Suspension and Expiration.** Whenever a member's DEA certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

2. **Probation.** Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

12.5.3 Failure to Satisfy Special Appearance Requirement. A member who fails without good cause to appear and satisfy the requirements of Section 10.6.3 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Committee specifies.

12.5.4 Medical Records. Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee. Failure to timely complete medical records shall result in a letter of admonishment and penalty as specified in the Three Rivers Health Rules and Regulations

12.5.5 Cancellation of Professional Liability Insurance. Failure to maintain professional liability insurance as required by these Bylaws or Rules shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

12.5.6 Failure to Comply with Government and Other Third Party Payor Requirements. The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency and professional review organization rules or policies is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Failure to comply with such shall result in the automatic suspension of the offending practitioner. The suspension shall be effective until the practitioner complies with such requirements.

12.5.7 Action by Another Peer Review Body. The Medical Executive Committee may automatically impose any adverse action that has been taken by a peer review body of another health care entity after the other entity conducted a hearing that the Medical Executive Committee reasonably believes satisfies the requirements of the Health Care Quality Improvement Act, provided that the other entity's actions were based upon standards that are or were substantially similar to those in effect at the Hospital at the time the automatic action will be taken.

12.5.8 Automatic Termination. If a practitioner is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

12.6 Alternate Medical Coverage for Patients of Suspended Practitioner: The Chief of Staff shall have the authority to provide for alternate medical coverage for patients of the suspended practitioner in

the Hospital when the practitioner is suspended. The Chief of Staff, in exercising such authority shall give full consideration to the preferences of the patients affected.

Article 13
HEARINGS AND APPELLATE REVIEWS

13.1 Purpose. The purpose of this Article and corresponding Rules is to provide a fair hearing and appellate review process to practitioners consistent with the requirements of the Health Care Quality Improvement Act of 1986, 42 USC § 11101 *et seq.* The terms and provisions of this Article and associated Rules shall be interpreted in accordance with and so as to comply with such statute. The Board of Trustees, the Medical Staff, and their officers, committees, and agents hereby affirm that they are peer review bodies under the Health Care Quality Improvement Act and any applicable state laws and claim all privileges and immunities afforded by federal and state laws.

13.2 Grounds for Fair Hearing and Appellate Review Process. Except as otherwise specified in these Bylaws or Rules (including but not limited to those Exceptions specified in Section 13.4), any of the following professional review activities or actions taken or recommended by a professional review body of the Hospital shall be deemed actual or potential adverse actions and entitle the member to the Hearing and Appellate Review Procedure described below if based on the competence or professional conduct of the practitioner, which conduct affects or could affect adversely the health or welfare of a patient or patients:

13.2.1 Denial of appointment or reappointment to the Medical Staff.

13.2.2 Denial of application for or renewal of privileges.

13.2.3 Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or privileges.

13.2.4 Involuntary imposition of significant consultation or proctoring requirements, except that a member shall not be entitled to a hearing based on consultation or proctoring requirements incidental to the granting of new privileges, or that are imposed because of insufficient activity, or that do not restrict the practitioner's privileges.

13.2.5 Summary suspension of Medical Staff membership and/or privileges, except that a member shall not be entitled to a hearing based on the member's summary suspension for a period of not longer than 14 days during which an investigation is being conducted to determine the need for a professional review action.

13.2.6 Any other disciplinary action or recommendation that must be reported to the Michigan State Board of Medicine or the National Practitioner's Data Bank.

13.3 Fair Hearing and Appellate Review Procedure. The practitioner who is subject to an adverse professional review action as specified in the preceding section shall be entitled to the Hearing and Appellate Review Procedure as set forth in the Rules, which procedure shall provide to the practitioner, unless waived, adequate notice and the opportunity for a hearing or such other procedures as are fair to the practitioner under the circumstances. Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws or Rules shall not be grounds for invalidating the action taken.

13.4 Exceptions to Fair Hearing and Appellate Review Process. The procedural rights set forth in this Article and Rules concerning the Hearing and Appellate Review Procedure do not apply to the following:

13.4.1 Reasons Not Based on Competence or Professional Conduct. Practitioners are not entitled to the procedural rights set forth in this Article or the Rules if adverse action was taken against the practitioner's membership and/or privileges for reasons that do not relate to the practitioner's competence or professional conduct that has affected or could affect adversely the health or welfare of a patient or patients.

13.4.2 Failure to Meet the Minimum Qualifications. Practitioners are not entitled to the procedural rights under this Article and the Rules if adverse action was taken against the practitioner's membership and/or privileges because of the failure to meet any of the Basic Qualifications in Article 2 or the failure to file a complete application.

13.4.3 Automatic Suspension or Limitation of Privileges. Practitioners are not entitled to the procedural rights under this Article and the Rules when adverse action has been taken against the practitioner's membership and/or privileges because the practitioner's legal credentials to practice have been revoked or suspended as set forth in Section 12.5. In the case of limitations or restrictions on licensure as described in Sections 12.5.1 and 12.5.2, the practitioner may request a hearing, but the issues at the hearing shall be limited to a determination as to whether the practitioner is able to practice at the Hospital with such limitations or restrictions, not whether the decision by the licensing or credentialing authority was warranted. Practitioners whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 12.5.3), failing to complete medical records (Section 12.5.4), failing to maintain malpractice insurance (Section 12.5.5), or failing to comply with particular government or other third party payor rules or policies (Section 12.5.7) are not entitled to the procedural rights in this Article and the Rules.

13.4.4 Failure to Meet Minimum Activity Requirements. Practitioners are not entitled to the procedural rights set forth in this Article and the Rules if adverse action is taken against their membership and/or privileges or their Medical Staff categories are affected because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the practitioner may request that the Board of Trustees reconsider or grant a deviation from the requirements for good cause. The Board of Trustees shall have discretion to grant or deny the request.

13.4.5 Exclusive Use Departments. The procedural rights set forth in this Article and the Rules do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated because the privileges he or she seeks are granted only pursuant to an exclusive use policy or exclusive contract. However, such practitioners shall have the right to request that the Board of Trustees review the denial, and the Board of Trustees shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the Board of Trustees.

13.4.6 Hospital Contract Practitioners. The procedural rights set forth in this Article and the Rules do not apply to practitioners who have contracted with the Hospital to provide clinical services. Removal of these practitioners from office and the termination of any exclusive privileges shall be governed by the terms of their individual contracts and agreements with the Hospital. However, the procedural rights of this Article and the Rules do apply if an action is taken which must be reported to the National Practitioner's Data Bank or the Michigan State Board of Medicine, or the practitioner's Medical Staff membership or privileges which are independent of the practitioner's contract are removed or suspended.

13.4.7 Allied Health Professionals. Allied health professionals (AHPs) are not entitled to the procedural rights set forth in this Article or the Rules concerning the Hearing and Appellate Review Procedure for practitioners. AHPs are entitled to the procedural rights referenced in Article 6 and Rules specific to AHPs.

13.5 Exhaustion of Remedies. If an adverse action as described in Section 13.2 is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws and the Rules before resorting to legal action.

13.6 Intra-Organizational Remedies. The hearing and appeal rights established in the Bylaws and Rules are strictly judicial rather than legislative in structure and function. Hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or policies. However, the Board of Trustees may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule or policy is lawful or meritorious, the practitioner is not entitled to a hearing or appellate review. In such cases, the practitioner must submit his challenges to the Board of Trustees before seeking judicial intervention.

13.7 Board of Trustees Committees. In the event the Board of Trustees should delegate some or all of its responsibilities described in this Article or the Rules to its committees, the Board of Trustees shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee, or to take such other action as it deems appropriate in the best interests of the Hospital and its patients.

Article 14
GENERAL PROVISIONS

14.1 Rules and Policies.

14.1.1 General Medical Staff Rules. The Medical Executive Committee shall adopt such Rules for the Medical Staff as it may deem necessary and shall periodically review and revise the Rules to comply with current Medical Staff practice. Recommended changes to the Rules may be submitted by members to the Medical Executive Committee for review and approval. Following approval by the Medical Executive Committee, a Rule shall become effective following approval of the Board of Trustees (which approval shall not be withheld unreasonably) or automatically within 60 days if no action is taken by the Board of Trustees. The adoption of Rules does not require a vote of the Medical Staff. If there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail. The Rules shall be deemed an integral part of the Medical Staff Bylaws.

14.1.2 Departmental Rules. Subject to the approval of the Medical Executive Committee and Board of Trustees, each department shall formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or Hospital bylaws, rules or other policies.

14.1.3 Medical Staff Policies. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and Rules. The policies may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Board of Trustees. Such policies shall not be inconsistent with the Medical Staff or Hospital bylaws, rules or other policies.

14.2 Forms. Application forms and any other prescribed forms required by these Bylaws and Rules for use in connection with Medical Staff appointments, reappointments, delineation of privileges,

corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the Board of Trustees. Upon adoption, they shall be deemed part of the Rules. They may be amended by approval of the Medical Executive Committee and the Board of Trustees.

14.3 Dues or Assessments. The Medical Executive Committee shall have the power to establish annual dues or assignments, if any, for each category of Medical Staff membership, subject to the Board of Trustees' approval, and to determine the manner of expenditure of such funds received consistent with applicable law.

14.4 Authority to Act. Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

Article 15
ADOPTION AND AMENDMENT OF BYLAWS

15.1 Medical Staff Responsibility and Authority. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Board of Trustees. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Trustees.

15.1.2 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least one-third (1/3) of the voting Medical Staff members.

15.1.3 Proposed amendments shall be submitted to the Board of Trustees for comments before they are distributed to the Medical Staff for a vote. The Board of Trustees has the right to have its comments regarding the proposed amendments circulated with the proposed amendments.

15.2 Methodology. Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

15.2.1 The affirmative vote of a majority of the Medical Staff members voting on the matter; and

15.2.2 The approval of the Board of Trustees, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Medical Executive Committee.

15.2.3 In the event the Medical Staff unreasonably fails to exercise its responsibility after notice from the Board of Trustees, the Board of Trustees may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with a court judgment.

15.2.4 Technical and Editorial Amendments. The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Trustees within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Board of Trustees.

Adopted by the Medical Staff:	December 21, 2017 Date Signed:
	____________________________________ Jessica Puckett, D.O., Chief of Staff
	____________________________________ __________________________, Secretary
Approved by the Authority Board:	Date Approved: Date Signed:
	____________________________________ Laurie Hines, Chairperson
	____________________________________ ______________________________, Secretary