WAYNE COUNTY HOSPITAL

CORYDON, IOWA

MEDICAL STAFF
BYLAWS

July 2016

WAYNE COUNTY HOSPITAL

MEDICAL STAFF BYLAWS

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WAYNE COUNTY HOSPITAL
MEDICAL STAFF
PREAMBLE

WHEREAS, Wayne County Hospital is a county public hospital established, licensed and operated under the laws of the State of Iowa; and

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

WHEREAS, it is recognized that the medical staff has been delegated responsibility and authority to assure the quality of medical and professional services provided by individuals with approved clinical and practice privileges, and accepts accountability for those services to the hospital governing body which retains ultimate authority; and

WHEREAS, it is recognized that the cooperative efforts of the medical staff, the chief executive officer and the governing body are necessary to fulfill the foregoing responsibilities of the medical staff and the hospital's obligations to its patients;

THEREFORE, the practitioners practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

DEFINITIONS

1) ALLIED HEALTH PROFESSIONAL (AHP) means an individual, other than a licensed physician, dentist or podiatrist, who exercises judgment within the areas of his/her professional competence and the limits established by the Board, the medical staff and the applicable State licensing acts, who is qualified to render direct or indirect medical, dental 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 rules adopted by the Board, these Bylaws and the Rules.

2) CHIEF EXECUTIVE OFFICER means the person appointed by the governing body to act on its behalf in the overall management of the hospital, or his/her authorized representative.

3) CHIEF OF SERVICE means the medical staff member duly appointed in accordance with these bylaws to serve as the head of a recognized hospital service.

4) CHIEF OF STAFF OR CHAIR means the chief elected officer of the medical staff.

5) CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a medical staff member to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services.

6) EXECUTIVE COMMITTEE means the executive committee of the medical staff, unless specific reference is made to the executive committee of the governing body.

7) GOVERNING BODY means the Board of Trustees of the hospital.

8) HOSPITAL means Wayne County Hospital.

9) MEDICAL STAFF or STAFF means the formal organization of all licensed practitioners, dentists, podiatrists and psychologists who are privileged to attend patients in the hospital.

10) MEDICO-ADMINISTRATIVE OFFICER means a practitioner, employed or engaged as an independent contractor by the hospital on a full-time or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners or employees under his/her direction.

11) PHYSICIAN means an individual with an M.D. or D.O. degree who is fully licensed to practice medicine.

12) PRACTICE PRIVILEGES means the permission granted to an allied health professional to participate in the provision of certain patient care services.

13) PRACTITIONER shall mean a physician or other licensed independent health care professional who holds or is eligible to be considered for clinical privileges under these Bylaws.

14) PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other hospital and medical staff rules, regulations or policies.

15) SERVICE means that group of practitioners or AHPs who have clinical or practice privileges in one of the general areas of medicine, surgery and obstetrics.

16) TELEMEDICINE means the use of electronic communication or other communication technologies to provide or support care at a distance. The medical staff determines which clinical services are appropriately delivered through this medium, according to commonly acceptable quality standards and applicable State law.

ARTICLE I: NAME

The name of this organization shall be the Wayne County Hospital Medical Staff.

ARTICLE II: PURPOSES

The purposes of this organization shall be:

1) To assure that all patients admitted to or treated in any of the facilities, departments or services of the hospital receive the appropriate level and quality of care;

2) to assure a high level of professional performance of all practitioners and AHPs authorized to practice in the hospital, through the appropriate delineation of clinical and practice privileges that each may exercise in the hospital, and through an ongoing review and evaluation of the care rendered by practitioners and AHPs in the hospital;

3) to provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing body and chief executive officer;

4) to initiate and maintain rules and regulations for the medical staff to carry out its responsibility to be self-governing with respect to the professional work performed in the hospital, pursuant to the authority delegated by the governing body in accordance with these bylaws; and

5) to provide education and maintain educational standards.

ARTICLE III: MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

3.1-1 IN GENERAL

Medical staff membership and clinical privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership on the medical staff shall confer on the member only such clinical privileges and prerogatives as have been granted by the governing body in accordance with these bylaws. No practitioner shall admit or provide services to patients in the hospital unless he/she is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws.

3.1-2 ONGOING EVALUATION OF NEEDS

From time to time, the governing body shall evaluate the number, category, admissions and hospital activities of medical staff appointees in various specialty areas, so that a proper number of individuals in each specialty is determined, maintained and revised as needed, in light of the professional requirements of the hospital and the needs of the community.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Practitioners shall be qualified for medical staff membership only if they:

(a) document their licensure or certification, experience, background, training, judgment, current clinical competence and physical and mental health with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized level of quality and efficiency established by the hospital and medical staff and that they are qualified to exercise clinical privileges within the hospital;

(b) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, to work cooperatively with others in the hospital setting, to be willing to participate in the proper discharge of medical staff responsibilities, and to work mutually with the Hospital in fulfilling their obligations related to patient care within the areas of their professional competence and credentials; and

(c) maintain their residence and medical practice closely enough to the hospital to provide timely and continuous care to their hospitalized patients. The ability to provide timelyand continuous care shall be defined on the basis of the geographic area within which a practitioner must reside and practice, and the practitioner's ability to arrange for alternate coverage. Any practitioner residing or regularly engaging in practice more than 30 minutes travel time from the hospital shall be required, as a prior condition of consideration for membership and privileges, to designate alternate coverage by a qualified practitioner who resides and regularly practices within 30 minutes travel time from the hospital. The designated alternate practitioner shall be a member in good standing of the medical staff with the requisite clinical privileges and shall have provided written consent to his/her alternate designation, which shall accompany the designating practitioner's application for membership and privileges. The designated alternate requirement shall be waived if the applicant agrees to remain within 30 minutes travel time from the hospital for the duration of the patient's hospital stay.

3.2-2 PARTICULAR QUALIFICATIONS

(a) Practitioners. An applicant for physician staff membership in the medical staff must hold a M.D. or D.O. degree issued by an accredited medical or osteopathic school approved by the Iowa Board of Medical Examiners, and a valid, unrevoked and unsuspended license to practice medicine issued to him/her by the Iowa Board of Medical Examiners.

(b) Advanced Practice Nurse. An applicant for staff membership in the medical staff must hold a Master's Degree of Nursing and a Nurse Practitioner or Certified Nurse Midwife degree issued by an accredited school of nursing and approved by the Iowa Board of Nursing, and a valid, unrevoked and unsuspended license to practice medicine by the Iowa Board of Nursing.

(c) Dentists. An applicant for dental staff membership in the medical staff must hold a D.D.S. degree issued by an accredited dental college approved by the Iowa Board of Dental Examiners and a valid, unrevoked and unsuspended license to practice dentistry issued to him/her by the Board of Examiners.

(d) Podiatrists. An applicant for podiatric staff membership on the medical staff must hold a D.P.M. degree issued by an accredited podiatry college approved by the Iowa Board of Podiatry Examiners and a valid, unrevoked and unsuspended license to practice podiatry issued to him/her by the Board of Examiners.

(e) Psychologists. An applicant for psychology staff membership on the medical staff must hold a doctoral degree issued by an institution approved by the Iowa Board of Psychology Examiners, a valid, unrevoked and unsuspended license to practice

psychology issued to him/her by the Board of Examiners, and must be a certified health service provider in psychology pursuant to the Code of Iowa. The applicant shall be registered by the National Register of Health Service Providers in Psychology.

3.3 AFFECT OF OTHER AFFILITATIONS

No practitioner shall be automatically entitled to medical staff membership, or to exercise any particular clinical privileges, merely because he/she holds a certain degree, is licensed to practice in Iowa or any other state, is a member of any professional organization, is a member of the faculty at a teaching institution, is certified by any clinical board, or had, or presently has, staff membership or privileges at this hospital or at another health care facility.

3.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, disability, creed, color or national origin, or on the basis of any other criterion unrelated to the delivery of quality patient care in the hospital setting, to professional qualifications, the hospital's purposes, needs and capabilities or community needs.

3.5 MEDICO-ADMINISTRATIVE OFFICERS

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

It shall further be the responsibility of all medico-administrative officers to provide in the contracts or agreements that they have with practitioners or AHP partners, employees, subcontractors and the like (herein referred to as "subcontractors") that privileges made exclusive or semi-exclusive to the holder of a contract or agreement, are likewise subject to automatic termination upon agreement with the hospital, or upon termination by the medico- administrative officer of his/her employment of, association with or partnership with the subcontractor. Failure of a medico-

administrative officer to include such provisions in his/her agreements with subcontractors shall not affect the hospital's right to deem or determine that the privileges of subcontractors have been automatically terminated in accordance with his/her provision of this section.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the medical staff shall:

(a) provide his/her patients with care at the generally recognized professional level of quality and efficiency established by the medical staff and the hospital;

(b) retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, or arrange for a suitable alternative to assure such continuous care and supervision;

(c) abide by the Medical Staff Bylaws and Rules and Regulations and by all other lawful standards, policies and rules of the hospital;

(d) comply with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations, including, but not limited to, those requiring attendance at meetings, maintenance of professional liability insurance, and refraining from unlawful fee splitting. It shall be understood that a compensation arrangement involving payment by a group practice to a physician member of the group practice is not unlawful fee splitting;

(e) discharge such personal, medical staff, service, committee and hospital functions, including, but not limited to, peer review, patient care audit, utilization review, emergency service call and back up functions, for which he/she is responsible by virtue of his/her staff category assignment, appointment, election, utilization of AHPs or exercise of privileges, prerogatives or other rights in the hospital;

(f) prepare and complete in timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the hospital;

(g) abide by the lawful ethical principles of his/her profession;

(h) aid in educational programs for medical staff members, AHPs and hospital personnel when requested and as appropriate;

(i) assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his/her professional competence and credentials.

3.7 DURATION OF APPOINTMENT

Initial appointments to the medical staff shall be for a period of not less than six (6) months or more than twenty-four (24) months. Except as otherwise recommended by the executive committee and approved by the governing body, reappointments shall be for a period of not more than two (2) full medical staff years. For the purposes of these bylaws, the medical staff year commences on the first day of January and ends on the last day of December of each year.

3.8 PROCTORING REQUIREMENT

3.8-1 FOR INITIAL APPOINTMENTS

Proctoring may be recommended by the executive committee of the medical staff. Proctoring may include direct observation of the practitioner's performance, outcome review, statistical trending, or other screening criteria as may be designated by the service chief. If proctoring is recommended, an initial appointee shall remain subject to proctoring until deemed completed by the executive committee.

3.8-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the executive committee, and approved by the governing body, medical staff members who change medical staff category or service assignment, or who are initially granted additional privileges, shall complete a period of proctoring

3.8-2.1 TERM OF PROCTORING PERIOD

The term of proctoring period shall be determined on a case-by-case basis.

3.9 LEAVE OF ABSENCE

3.9-1 LEAVE STATUS

A medical staff member may obtain a leave of absence from the medical staff by submitting written notice to the executive committee and the CEO/agent stating the approximate period of time of the leave, which may not exceed two (2) years. During the period of the leave, the member's clinical privileges, prerogatives and responsibilities shall be suspended.

Any medical staff member who seeks to resume his/her hospital practice following a medical or personal leave shall be required to meet with the executive committee prior to resuming practice,for the purpose of ascertaining whether any restrictions on the individual's practice are indicated.

3.9-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave, the medical staff member shall request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the CEO/agent and to the executive committee. The staff member shall submit a written summary of his/her relevant activities during the leave. The executive committee shall recommend whether to approve the member's request for reinstatement of his/her privileges and prerogatives.Thereafter, the procedure set forth in Sections 6.3-5 through 6.3-8 shall be followed.

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

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The medical staff shall be divided into active; courtesy, consulting; emergency service; honorary; associate dental, podiatry and psychology; and reference categories.

4.2 ACTIVE MEDICAL STAFF

4.2-1 QUALIFICATIONS

The active medical staff shall consist of practitioners who:

(a) meet the qualifications set forth in Section 3.2;

(b) regularly admit patients to, or otherwise regularly provide professional services for patients in, the hospital.

4.2-2 PREROGATIVES

The prerogatives of an active medical staff member shall be to:

(a) admit patients or provide services for patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations. ARNP's will be allowed to admit and manage inpatients with a co-admitting physician. Certified Nurse Midwife will be allowed to admit to the obstetrical unit independently;

(b) exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(c) hold office in the medical staff and in the service and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws;

(d) vote for medical staff officers, on bylaws amendments, and on all matters presented at general and special meetings of the medical staff and of the service and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.2-3 RESPONSIBILITIES

Each active medical staff member shall:

(a) meet the basic responsibilities set forth in Section 3.6;

(b) actively participate in and regularly assist the hospital in fulfilling its obligations related to patient care including, but not limited to, emergency service call and backup, patient care audit, peer review, utilization review, quality evaluation, and related monitoring activities required of the medical staff in supervising and proctoring initial appointees and AHPs and in discharging such other functions as may be required from time to time;

4.3 COURTESY STAFF

4.3-1 QUALIFICATIONS

The courtesy staff shall consist of practitioners who:

(a) meet the qualifications set forth in Section 3.2;

(b) admit, or otherwise provide professional services for, not more than twenty (20) patients in the hospital during each medical staff year;

(c) are members in good standing of the active medical staff of another hospital in the same or similar category of privileges, and authorize hospital to verify their standing in such other hospital(s) on a periodic basis.

4.3-2 PREROGATIVES

The prerogatives of a courtesy staff member shall be to:

(a) admit, or provide professional services for, not more than twenty (20) patients in the hospital during each medical staff year. Members whose activity will exceed this limit must apply and qualify for active staff status;

(b) exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(c) attend meetings of the medical staff and the department of which he/she is a member. A courtesy staff member may be requested to serve on standing or special committees, butmay not hold office in the medical staff or in the service of which he/she is a member;

(d) a courtesy staff member may vote on committees on which he/she serves, but may not vote on any medical staff matter.

4.3-3 RESPONSIBILITIES

Each courtesy staff member shall meet the basic responsibilities set forth in Section 3.6, exceptas modified for (e).

4.4 CONSULTING STAFF

4.4-1 QUALIFICATIONS

The consulting staff shall consist of practitioners w h o :

(a) meet the qualifications set forth in Section 3.2, except that this requirement shall not preclude an otherwise qualified out of state practitioner from appointment within the limitations of Iowa law;

(b) possess clinical expertise and come to the hospital when so scheduled or when called to render a clinical opinion or service within their competence;

(c) are members in good standing of the active medical staff of another hospital in the same or similar category of privileges, and authorize the hospital to verify their standing is such other hospital(s) on a periodic basis.

4.4-2 PREROGATIVES

The prerogatives of a consulting staff member shall be to:

(a) exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(b) attend meetings of the medical staff and the service of which he/she is a member. A consulting staff member may be requested to serve on standing or special committees, but may not hold office in the medical staff or in the service of which he/she is a member;

(c) vote on committees on which he/she serves, but may not vote on any medical staff matter.

4.4-3 RESPONSIBILITIES

Each consulting staff member shall meet the basic responsibilities set forth in section 3.6.

4.5 EMERGENCY SERVICE STAFF

4.5-1 QUALIFICATIONS

The emergency service staff shall consist of practitioners who:

(a) are licensed to practice medicine in the State of Iowa or are concurrently enrolled in good standing in an accredited medical residency training program, and who meet the qualifications set forth in Section 3.2; and

(b) provide professional services for patients in the hospital emergency service.

4.5-2 PREROGATIVES

The prerogatives of an emergency service staff member shall be limited to:

(a) assessing and treating patients in the emergency department;

(b) admitting patients as necessary on behalf of and in consultation with members of the active medical staff;

(c) exercising such clinical privileges as are granted to him/her pursuant to Article VII.

4.5-3 RESPONSIBILITIES

Each emergency service staff member shall meet the basic responsibilities set forth in Section 3.6.

4.6 HONORARY STAFF

4.6-1 QUALIFICATIONS

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

4.6-2 PREROGATIVES

Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and service meetings and any staff orhospital education meetings. An honorary staff member may not vote on any medical staff matter,hold office in the medical staff or in the service of which he/she is a member, or serve on committees.

4.6-3 RESPONSIBILITIES

Each honorary staff member shall meet the basic responsibilities specified in Section 3.6, paragraphs (c), (d) and (g).

4.7 ASSOCIATE DENTAL, PODIATRY AND PSYCHOLOGY STAFF

4.7-1 QUALIFICATIONS

The associate staff shall consist of dentists, podiatrists and certified health service providers in psychology who:

(a) meet the qualifications set forth in Section 3.2.

(b) admit and treat patients, only by co-admitting each patient with a physician member of the medical staff who has admitting privileges who assumes, as required by Section 7.3 hereof, responsibility for care of the patient's medical problems.

4.7-2 PREROGATIVES

The prerogatives of associate staff members shall be to:

(a) admit and treat patients, only by co-admitting each patient with a physician member of the medical staff who has admitting privileges and who assumes, as required by Section 7.3 hereof, responsibility for care of the patient's medical problems;

(b) exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(c) attend meetings of the medical staff and service of which he/she is a member. A member of the associate staff may not hold office in the medical staff, but may vote on any matters presented at general and special meetings of the medical staff that are related to his/her area of practice.

4.7-3 RESPONSIBILITIES

Each associate staff member shall meet the basic responsibilities set forth in Section 3.6.

4.8 REFERENCE STAFF

The reference staff shall consist of practitioners, dentists, podiatrists and certified health providers in psychology who wish to refer their patients to the hospital for outpatient diagnostic or therapeutic procedures to be performed by hospital personnel, but who do not wish to apply or do not qualify for privileges to admit or provide services to patients. Orders from members of the reference staff for outpatient procedures to be performed by hospital personnel, may be executed without a countersignature by any other member of the medical staff.

The Credentials Committee will determine what procedures and tests a reference staff may order. Only those tests or procedures approved by the Credentials Committee and the Governing Body will be allowed to be ordered by the reference staff member.

Practitioners applying for reference staff privileges must provide documentation of their current unrestricted license to practice in the State of Iowa and their professional liability insurance coverage. These practitioners shall be exempt from committee assignments, consultation assignments, continuous care and patient supervision requirements, emergency service rotation and proctoring. These practitioners shall not be expected to attend medical staff meetings, and shall not be permitted to vote or hold office on the medical staff.

4.9 TELEMEDICINE STAFF

The telemedicine staff shall consist of physicians providing care, treatment and services of patients only via an electronic communication link. These physicians are subject to the credentialing and privileges process of these Bylaws and the Medical Staff Rules and Regulations. The medical staff will define in its Rules and Regulations or medical staff policies which clinical services are appropriately delivered through a Telemedicine medium, according to commonly accepted quality standards. The Governing Body will make the final decision on what clinical services will be delivered at the hospital through telemedicine medium. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions. The Governing Body will develop and implement contract language for written agreements for hospital based and separate entity based telemedicine services desired and approved by the medical staff. These contracts will conform to the CMS Conditions of Participation described in 42 C.F.R., Subpart F, Sections 482.12(a)(1.8), 482.22(a)(3), 485.616, 485.635, and 485.641. A specific Policy and Procedure for the process of credentialing and privileging of distant site Telemedicine Physicians will be implemented.

A telemedicine staff may (a) treat patients via electronic communication link, except as set for in department rules and regulations, privilege criteria and Hospital policies; (b) exercise such clinical privileges as are granted by the Governing Body; (c) be appointed to committees unless otherwise provided by these Bylaws; and (d) vote on matters presented

at committees to which he or she has been appointed unless otherwise limited by these Bylaws or the Rules and Regulations. Telemedicine Staff may not admit patients. A telemedicine staff may not vote on matters presented at any meeting of the medical staff or hold office at any level in the medical staff.

Telemedicine staff must, in addition to meeting the basic obligations set forth in these Bylaws (a) contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the medical staff; and (b) pay dues if applicable.

4.10 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws, by the Medical Staff Rules and Regulations, or by other policies of the hospital. The prerogatives of dental, podiatric and psychology staff members of the medical staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education,training and experience.

ARTICLE V: ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

The governing body, in consultation with the executive committee, shall determine the services to be provided in the hospital and the categories of AHPs eligible to provide services in the hospital. Allied health professionals (AHPs) holding a license, certificate or such other legal credentials, if any, as required by Iowa law, which authorize the AHPs to provide certain professional services, are not eligible for medical staff membership. However, such AHPs are eligible to apply for practice privileges in his/her hospital if they:

(a) hold a current, unrestricted license, certificate, or other legal credential in a category of AHPs which the governing body has identified as eligible to apply for practice privileges;

(b) document their experience, background, training, demonstrated ability, current clinical competence, judgment and physical and mental health with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges within the hospital;

(c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively and

harmoniously with others in the Hospital setting; and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials; and

(d) provide acceptable evidence of professional liability insurance coverage for the term of the requested appointment or reappointment in an amount not less than that determinedby the governing body.

5.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

For each eligible AHP category, the mode of practice in the hospital setting (i.e., independent or dependent) and the practice privileges and prerogatives that may be granted to qualified AHPs in that category shall be identified. The governing body shall secure recommendations from the Executive Committee as to the categories of AHPs which should be eligible to apply for practice privileges and as to the practice privileges, prerogatives, terms and conditions which may be granted and apply to AHPs in each category. The delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms and conditions for each such AHP category, when approved by the executive committee and the governing body, shall be set forth in the Medical Staff Rules and Regulations or in an appendix thereto.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges, and subsequent renewal thereof, shall be submitted and processed in a parallel manner to that provided in Articles VI and VII for practitioners, unless otherwise specified in these bylaws or the Medical Staff Rules and Regulations. An AHP shall not be subject or entitled to the hearing and appeal provisions set forth in Article IX of these bylaws; review procedures for AHPs shall be controlled by this Article V.

An AHP who does not have licensure or certification in an AHP category identified as eligible for practice privileges in the manner required by Section 2 above may not apply for practice privileges, but may submit a written request to the CEO/agent, asking that the governing body consider identifying the appropriate category of AHPs as eligible to apply for practice privileges. The governing body may refer the request to the executive committee for recommendation; and the governing body may consider such request before the time of its annual review of the categories of AHPs, but shall consider such request no later than its annual review.

Each AHP shall be assigned to the clinical service appropriate to his/her occupational or professional training and, unless otherwise specified in these bylaws or the rules and regulations, shall be subject to terms and conditions paralleling those specified in Article VI, as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

5.4 PREROGATIVES

The prerogatives which may be extended to an AHP shall be defined in the Medical Staff Rules and Regulations or hospital policies. Such prerogatives may include:

(a) provision of specified patient care services independently or under the supervision or direction of a physician member of the active medical staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification;

(b) service on medical staff, service and hospital committees;

(c) attendance at the meetings of the service to which he/she is assigned, as permitted by the service, and attendance at hospital education programs in his/her field of practice.

5.5 RESPONSIBILITIES

Each AHP shall:

(a) meet those responsibilities required by the Medical Staff Bylaws, Rules and Regulations, and if not so specified, meet those responsibilities specified in Article III as are generally applicable to the more limited practice of the AHP;

(b) retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the hospital for whom he/she is providing services;

(c) participate, as appropriate, in patient care audit and other quality review, evaluation and monitoring activities required of AHPs in supervising initial appointees of his/her same occupation or profession, or of a lesser included occupation of profession, and in discharging such other functions as may be required from time to time; and

(d) abide by the same provisions applicable to practitioners in Sections 11, 12 and 13 of the Medical Staff Rules and Regulations, entitled "Chemically Impaired

Practitioners","Sexual Harassment" and "Disruptive Practitioners".

5.6 TERMINATION OF PRIVILEGES

An AHP's privileges shall automatically terminate, without right of review, in the event:

(a) the medical staff membership, contract or related privileges of the supervising physicianare terminated or suspended, whether such termination or suspension is voluntary or involuntary, or when the supervising physician is no longer a member of the active staff; or

(b) the supervising physician no longer agrees to act as the supervising physician for any reason, or the relationship between the AHP and the supervising physician is otherwiseterminated, regardless of the reason; or

(c) the AHP's certification expires, is revoked or is suspended; or

(d) the AHP fails to maintain the required professional liability coverage.

The AHP's privileges may also be terminated or suspended for other reasons by the chief of the service to which he/she is assigned, the Chief of Staff or the hospital CEO/agent, subject to the review procedure set forth in Section 5.7.

5.7 REVIEW PROCEDURE

Nothing contained in these bylaws shall be interpreted to entitle an AHP to the corrective action, hearing and appeal rights and obligations applicable to members of the medical staff in Articles VIII and IX. However, in any action taken against a member of the AHP staff for reasons other than automatic termination of privileges for the reasons specified in Section 5.6 above, that would constitute grounds for a hearing under section 9.2 of these bylaws, the AHP shall have the right to file a written grievance with the chief of the clinical service to which the AHP has been assigned and in which he/she has practice privileges within 15 days of such action.

Upon receipt of such a grievance, the service chief shall conduct an investigation that affords the affected AHP an opportunity for an interview before a service review committee, which shall beappointed by the service chief. The committee shall include, for the purpose of this interview,the service chief/agent, an AHP holding the same or similar license or certificate as the affected AHP if available, the hospital CEO/agent, and such other hospital or medical staff members as the service chief may deem appropriate under the circumstances. The interview shall not constitute the same type of "hearing" as is established for members of the medical staff in Article IX of these

bylaws, and shall not be conducted according to the procedural rules applicable to those hearings. Before the interview, the affected AHP shall be informed of the general nature of the circumstances giving rise to the action or proposed action, and at the interview, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. A report of the findings and recommendations shall be made by the service chief to the executive committee which shall make its recommendation to the governing body, whose decision shall be final and binding.

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

5.8 MEDICAL AND SURGICAL ASSISTANTS

Medical and surgical assistants are persons who are not employees of the hospital, and who are not members of the medical staff or of the regular allied health professional staff, but who work from time to time in the hospital and are employed by and responsible to members of the medical staff and work under the medical staff member's direction and supervision. Supervising medical staff members shall show proof of liability insurance covering the medical or surgical assistant involved. All medical and surgical assistants who request privileges to provide services in the hospital under the direction and supervision of a medical staff member shall do so on an appropriate form approved by the governing body. Applicants shall submit information pertaining to their educational background and their experience and training in the specialty in which the privileges are requested. Medical and surgical assistants shall be governed by the sections on Termination of Privileges and Right of Review set forth in this Article V.

5.9 STUDENTS, RESIDENTS AND INTERNS

Students who are concurrently enrolled in an accredited medical training program may apply for privileges to observe, assess and/or treat patients in the hospital under the direction and supervision of a member of the medical staff utilizing the appropriate application packet.

ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

6.1-1 PREAPPLICATION REQUIREMENT

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

6.1-2 NATURE OF MEDICAL STAFF CONSIDERATION

The medical staff, through its designated services, committees and offices, shall consider each application for appointment or reappointment to the staff, and for clinical privileges, utilizing the resources of the CEO/agent and his/her staff to investigate and validate the contents of each application, before adopting and transmitting its recommendation to the governing body.

The medical staff shall also perform the same function in connection with any individual who has applied only for temporary privileges, or who otherwise seeks to exercise privileges or to provide specified services in any hospital service.

6.2 APPLICATION FOR APPOINTMENT

6.2-1 CONTENT

All applications for appointment to the medical staff shall be in writing, and shall be signed by the applicant and submitted on a form prescribed by the executive committee and approved by the governing body, with all provisions completed (or an explanation of why answers are unavailable). The applicant shall also identify the staff category, clinical service and clinical privileges for which the applicant wishes to be considered. The application shall require detailed information including, but not limited to:

(a) the applicant's professional qualifications, competency, Iowa Licensure, current DEA registration, continuing medical education related to the clinical privileges to be

exercised by the applicant, and ACLS certification;

(b) at least three peer references familiar with the applicant's professional qualifications, current professional competency and ethical character;

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

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

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

(f) details of any prior or pending government agency proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions;

(g) the applicant's ability to carry out the responsibilities and prerogatives of the medical staff membership category and to perform the clinical privileges applied for with reasonable skill without exposing the applicant or others to significant health or safety risks;

(h) certification of the applicant's agreement to terms and conditions set forth in

Section 6.2-2 regarding the effect of the application;

(i) an acknowledgment that the applicant has received (or has been given access to) the Medical Staff Bylaws and Rules and Regulations, that he/she has received an explanation of the requirements set forth therein and of the appointment process, and that he/she agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application.

6.2-2 EFFECT OF APPLICATION

By applying for appointment to the medical staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application; authorizes the hospital and its representatives or its designees to consult with members of medical staffs of other hospitalswith which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications, ability and willingness to work harmoniously with others, moral and ethical qualifications for membership, professional competence, ability to carry out the requirements with reasonable skill and safety without exposing the applicant or others to significant health or safety risks, and directs individuals who have custody of such records and documents to information submitted on the application form, which may subsequently occur, to the executive committee and the CEO/agent; and releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the hospital concerning the applicant and all hospital representatives for their acts performed in connection with evaluating the applicant and his/hercredentials.

6.3 PROCESSING THE APPLICATION

6.3-1 APPLICANT'S BURDEN

In addition to all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her qualifications and ability to perform the requirements and prerogatives of the membership category and privileges applied for with reasonable skill and safety and for resolving any reasonable doubts about these matters, and of satisfying requests for information.The applicant's failure to sustain this burden shall be deemed a voluntary withdrawal of the application. Failure to adequately complete

and update the application form, failure to provide requested information, or providing false or misleading information, shall, in and of itself, constitute a basis for denial or revocation of medical staff appointment.

6.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the CEO/agent who shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (HCQIA), as amended, the hospital/agent will query the National Practitioner Data Bank. The CEO/agent shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six (6) months after it was received by the CEO/agent shall be deemed to have voluntarily withdrawn his/her application from consideration for Staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, have been resubmitted.

The hospital may contract with a credentials verification service to assist in collecting and verifying information necessary for consideration of appointment and privileges. When collection and verification is accomplished, the CEO/agent shall transmit the application and allsupporting materials to the chief of the medical staff for evaluation by the executive committeeand the chief of the service in which the applicant seeks privileges.

6.3-3 EXECUTIVE COMMITTEE ACTION

Within thirty (30) days after receipt of the completed application, and supporting documentation, the executive committee, and the chief of the service in which the applicant seeks privileges if the service chief is not a member of the executive committee shall review the application, the supporting documentation, and such other relevant information as may be available. The executive committee may ask the applicant to appear for an interview or request further documentation. The committee shall then forward to the CEO/agent, for transmittal to the governing body, its written report and recommendations, prepared in accordance with Section 6.3-4. The committee may also defer action on the application pursuant to Section 6.4-6(a).

6.3-4 APPOINTMENTS REPORTS

The service chief and executive committee reports and recommendations shall be submitted in the form prescribed by the executive committee. Each report and recommendation shall specify whether medical staff appointment is recommended, and if so, the membership category, service affiliation and clinical privileges to be granted and

any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

6.3-5 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for medical staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2, can carry out the responsibilities specified in Section 3.6, and meets all of the standard requirements set forth in all sections of these bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession and other hospitals' Medical Staff Bylaws, Rules and Regulations, and policies; rendering of services to his/her patients; his/her ability to carry out the requirements and prerogatives of staff membership and perform the clinical privileges applied for with reasonable skill and safety; his/her provision of accurate and adequate information to allow the medical staff to evaluate his/her competency and qualifications; and information obtained from the National Practitioner Data Bank and other data sources as appropriate.

6.3-6 EFFECT OF EXECUTIVE COMMITTEE ACTION

(a) Interviews, Further Documentation, Deferral: Action by the executive committee to interview the applicant, seek further documentation or defer the application for further consideration must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for medical staff membership.

(b) Favorable Recommendation: When the executive committee's recommendation is favorable to the applicant, the CEO/agent shall promptly forward it, together with all supporting documentation, to the governing body. For the purpose of this Section 6.3-6 (b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the service chief and the executive committee.

(c) Adverse Recommendation: When the executive committee's recommendation is adverse to the applicant, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2, and the applicant shall be entitled to the procedural rights as provided in Article IX. For the purposes of this Section 6.4-8(c), an "adverse recommendation" by the executive committee is as defined in Section 9.2. The governing body shall be informed of, but not take action on, the

pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

6.3-7 ACTION BY THE GOVERNING BODY

(a) On Favorable Executive Committee Recommendation: The governing body shall, in whole or in part, adopt or reject an executive committee recommendation which is favorable to the applicant or refer the recommendation back to the executive committee for further interviews, documentation or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the governing body is one of those set forth in Section 9.2, the CEO/agent shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(b) Without Benefit of Executive Committee Recommendation: If the governing body does not receive an executive committee recommendation within the time period specified in Section 6.3-10, it may, after notifying the executive committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the governing body. If the recommendation is one of those set forth in Section 9.2, the CEO/agent shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse executive committee recommendation pursuant to Section 6.3-6(c) or an adverse governing body recommendation pursuant to Section 6.3-7(a) or (b), the governing body shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article IX. Action thus taken shall be the conclusive decision of the governing body, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the governing body shall make a final decision.

6.3-8 NOTICE OF FINAL DECISION

(a) Notice of the governing body's final decision shall be given, through the CEO/agent, to the executive committee and the applicant.

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

6.3-9 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

An applicant who (a) has received a final adverse decision regarding appointment or (b) withdrew his/her application or request for membership or privileges following an adverse recommendation by the executive committee or governing body; (2) a former medical staff member who has (a) received a final adverse decision resulting in termination of medical staff membership and clinical privileges or (b) resigned from the medical staff following the issuance of a medical staff or governing body recommendation adverse to he/she member's medical staffmembership or privileges; or (3) a medical staff member who has received a final adverse decision resulting in (a) termination or restriction of his/her clinical privileges or (b) denial of his/her request for additional clinical privileges, shall not be eligible to reapply for medical staffmembership and/or clinical privileges affected by the previous action for a period of at least one year from the date of the adverse decision became final, the date the application or request waswithdrawn or the date the former medical staff member's resignation became effective,whichever is applicable.

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

After the one-year period, the former applicant, former medical staff member or medical staff member may request an application for medical staff membership and/or privileges, which shall be processed as an initial application. The former applicant, former medical staff member or medical staff member, shall also furnish

evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which form the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the executive committee that he/she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The executive committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to fu1iher review by the governing body within forty-five (45) days after the executive committee decision was rendered.

6.3-10 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in the Section 6.3-10. The CEO/agent shall transmit the completed application to the executive committee within thirty-five (35) days after all information collection and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within sixty (60) days after the application is received by the CEO/agent the applicant shall be notified, and the application shall remain pending until either the materials are received by the CEO/agent or the expiration of six (6) months from the date the application was received. Applications which are not completed within six months after receipt shall automatically be removed from consideration. The executive committee shall make a recommendation to the governing body within forty-five (45) days after receiving the application. The governing body shall then take final action on the application within forty-five (45) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his or her application processed within those periods.

6.4 REAPPOINTMENTS

6.4-1 APPLICATION FOR REAPPOINTMENT: SCHEDULE FOR REVIEW

At least ninety (90) days prior to the expiration of each practitioner's and AHP's current staff appointment, the CEO/agent shall mail a reappointment application to the staff member.

At least sixty (60) days prior to the expiration date of his/her staff appointment, each practitioner and AHP shall submit to the CEO/agent a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the medical staff and approved by the governing body, and it shall require

detailed information concerning the changes in the applicant's qualifications since his/her last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 6.2, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the applicant requests any change in his/her staff status and/or in his/her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence that would be necessary for such privilege to be granted in an initial application for same.

6.4-2 VERIFICATION OF INFORMATION

The CEO/agent shall, in timely fashion, seek to collect or verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. The hospital may contract with a credentials verification service to assist in collecting and verifying information necessary for consideration of reappointmentand privileges. The CEO/agent shall provide a summary report regarding the quality assessment activities for each physician regarding the previous credentialing period and shall transmit the completed reappointment application form and supporting materials to the chief of the medical staff for evaluation by the executive committee and the chief of each service in which the individual has or requests privileges.

6.43 EXECUTIVE COMMITTEE ACTION

The executive committee shall review the completed application and supporting documents, the service chief's report and all other relevant information available to it, and shall forward to the governing body, through the CEO/agent, its favorable reports and recommendations, prepared in accordance with Section 6.4-4.

When the executive committee recommends adverse action, as defined in Section 9.2, either in respect to reappointment or clinical privileges, the CEO/agent shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2, and the applicant shall be entitled to the procedural rights as provided in Article IX. The governing body shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his/her procedural rights.

The procedures specified in Sections 6.3-6 (Action by the Governing Body) and; 6.3-7 (Notice of Final Decision) shall be followed. The committee may also defer action; however, any such deferral must be followed up within sixty (60) days with a subsequent recommendation.

6.4-4 REAPPOINTMENT REPORTS

The executive committee and service chief's reports and recommendations shall be written and shall be submitted in the form prescribed by the executive committee. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, service affiliation, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status or change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-5 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of a practitioner or AHP and the clinical privileges to be granted upon reappointment shall be based upon whether such individual has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.6, and met all of the standards and requirements set forth in all sections of these bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with the Medical Staff Bylaws and Rules and Regulations and hospital policies; rendition of services to his/her patients; ability to carry out the requirements and prerogatives of staff membership and perform the clinical privileges applied for with reasonable skill and safety; his/her provision of accurate qualifications; and information obtained from the National Practitioner Data Bank and other data sources as appropriate.

6.4-6 EXTENSION OF APPOINTMENT

If the application for reappointment has not been fully processed by the expiration date of the appointment, the staff member shall maintain his/her current membership status and clinical privileges until such time as the processing is completed, unless corrective action is taken with respect to all or part thereof, or unless the delay is due to the member's failure to return the reappointment application form completed as required. Such extension of an appointment shall not be deemed to create a right for the member to be automatically reappointed for the coming term.

6.4-7 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure to file an application for reappointment within the time period and completed as required by Section 6.4-1, shall result in the automatic suspension of the practitioner's or AHP's privileges and prerogatives, unless otherwise extended by the executive committee with the approval of the governing body. If the individual fails to submit an application for reappointment completed as required, on or before the expiration date of his/her

appointment, he/she shall be deemed to have voluntary resigned his/her membership in the medical staff or the allied health professional staff.

6.4-8 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges and prerogatives. A member of the medical staff whose membership is automatically terminatedshall be entitled to the procedural rights provided in Article IX for the sole purpose of determining whether or not the failure to request reinstatement was unintentional or excusable. A subsequent request for medical staff membership received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE VII: CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner or AHP providing clinical services at the hospital by virtue of medical staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically granted to him/her by the governing body, except as provided in Sections 7.4 and 7.5 of this Article VII.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

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

7.2-2 BASIS FOR PRIVILEGE DELINEATION

Requests for privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated competence, and ability to practice with reasonable skill and safety andjudgment. The elements to be considered in making determinations regarding privileges, whether in connection with periodic reappointments or otherwise, shall include education, training, observed clinical performance and judgment, the applicant's health, performance of a sufficient number of procedures each year todevelop and maintain the practitioner's skills and knowledge, continuing medical education information related to the clinical privileges to be exercised by the applicant, and the

documented results of the patient care audit and other quality review, evaluation, and monitoring activities required by these and the hospital bylaws to be conducted at the hospital. Privileges determinations shall also take into account pertinent information concerning clinicalperformance obtained from other sources, especially other institutions and health care settingswhere a member exercises clinical privileges.

When considering a request from a physician who practices telemedicine, credentialing information from the originating facility may be used so long as the decision to delineate privileges is made by the Governing Body and consistent with the requirements of CMS Conditions of Participation regarding telemedicine privileges and as more fully identified in Section 4.9 of these Bylaws.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI for members of the medical staff, and in Article V for AHP staff if they differ from Article VI. If a practitioner is granted privileges to perform a procedure in the hospital, the practitioner shall be deemed to be privileged to perform that procedure via the telemedicinenetwork, if applicable, unless otherwise expressly limited.

7.3 SPECIAL CONDITIONS APPLICABLE TO LIMITED LICENSE PRACTITIONERS

Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the chief of the surgical service/agent. All dental and podiatric patients shall be co-admitted by a physician medical staff member and receive the same basic medical appraisal as patients admitted to other surgical services. The physician medical staff membershall be responsible for the care of any medical problem that may be present at the time of admission, or that may arise during hospitalization. Requests for clinical privileges from dentists and podiatrists shall be processed in the manner specified in Section 7.2.

7.4 TEMPORARY PRIVILEGES

7.4-1 CONDITIONS

Temporary privileges may be granted only when the practitioner has submitted a written request for appointment or a written request for temporary privileges and the information available reasonably supports a favorable determination regarding the requesting practitioner's licensure, qualifications, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement regarding professional liability insurance. Request for temporary privileges must be accompanied by: 1) current license, 2) proof of liability insurance, 3) DEA Certificate, 4) State Narcotic Certificate, 5) CV. Before temporary privileges are granted, the practitioner must

acknowledge in writing that he/she has received, or has been given access to, the Medical Staff Bylaws and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

7.4-2 CIRCUMSTANCES

Upon the written concurrence of the CEO/agent and the Chief of Staff/agent, temporary privileges may be granted by the CEO/agent to a practitioner, subject to the conditions set forth in Section 7.4-1 above, in the following circumstances:

A. Pendency of Application

After acceptance of an application from an appropriately licensed practitioner, an applicant may be granted temporary clinical privileges for an initial period of thirty (30) days with subsequent renewals not to exceed the pendency of the application.

B. Care of Specific Patients

Specific temporary clinical privileges may be granted to a practitioner, who is not an applicant for membership, for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than three (3) patients in any one year by any practitioner, beyondwhich such practitioner shall be required to apply for membership on the medical staff before being granted the requested privileges or allowed to attend additional patients.

C. Locum Tenens

Upon acceptance of the prescribed written application for specific temporary privileges, a practitioner of documented competence who is serving as a locum tenens for a member of the medical staff and who is a member in good standing of the active staff of another hospital may be permitted to attend patients without applying for membership on the medical staff, for a period not to exceed thirty (30) days, providing all of his/her credentials have first been approved by the chairman of the executive committee. Such privileges may be renewed for two (2) successive periods of thirty (30) days but not to exceed his/her services as locum tenens, and shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens. He/she shall provide satisfactory evidence of the level of professional liability insurance required of medical staff members under these bylaws. He/she shall not be entitled to admit his/her own patients to the hospital.

7.4-3 TERMINATION

Upon the discovery of any information, or the occurrence of any event, of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with any Bylaws, Rules, Regulations or special requirements, the CEO/agent or the Chief of Staff may, after consultation with the service chief responsible for supervision, or his/her designee, terminate any or all of such practitioner's temporary privileges. However, where it is determined that the life or well-being of a patient would be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose a summary suspension pursuant to Article VIII of these bylaws, and the same shall be immediately effective. In such event, the chief of service responsible forsupervision or, in his/her absence, the chairman of the executive committee, shall assign a member of the medical staff to assume responsibility for the care of the terminated practitioner's patients then in the hospital. The wishes of the patient shall be considered, where feasible, in assigning a substitute practitioner.

7.4-4 RIGHTS OF THE PRACTITIONER

A practitioner shall not be entitled to the procedural rights afforded by Article IX because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

7.5 EMERGENCY PRIVILEGES

For the purposes of this section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death, and any delay in administering treatment would add to that danger. In the case of emergency, any practitioner, to the degree permitted by his/her license and regardless of service, or medical staff status, or clinical privileges, shall be permitted and assisted to do everything possible to save the patient from such danger. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are not requested or denied, the patient shall be assigned to an appropriate member of the medical staffby the Chief of Staff/agent.

ARTICLE VI II: CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 CRITERIA FOR INITIATION

When a practitioner with clinical privileges engages in unprofessional conduct, either in or outside of the hospital, and such conduct may be detrimental to patient safety or delivery of patient care or disruptive to hospital operations, an investigation or corrective action against the practitioner may be requested by any officer of the medical staff, the governing body or the CEO/agent.

8.1-2 PEER REVIEW CONFIDENTIALITY

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

8.1-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by the executive committee on its own initiative or by a written request which is submitted to the executive committee and identifies the specific activities or conduct which is alleged to constitute the ground for proposing an investigation or specific corrective action. The Chief of Staff shall promptly notify the CEO/agent and governing body of all proposals for corrective action so initiated and shall continue to keep them fully informed of all action taken in conjunction therewith.

8.1-4 INVESTIGATION

Upon receipt, the executive committee shall take action on the proposal or direct that an investigation be undertaken. The executive committee may conduct that investigation itself or may assign this task to an appropriately charged officer, or standing or ad hoc medical staff committee. No such investigative process shall be deemed to be a "hearing" as described in Article IX.

During the investigative process, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the investigating officer or

body. Atsuch interview, the practitioner shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of the interview shall be made and included in the report to the executive committee. If the investigation is delegated to an officer or committee other than the executive committee, such officer or committee shall forward a written report of the investigation to the executive committee, as soon as is practicable under the circumstances, but in any event within thirty (30) days after the assignment to investigate has been made, unless extended for good cause shown.The executive committee may at any time within its discretion, and shall at the request of thegoverning body, terminate the investigative process and proceed with action as provided in Section 8.1-5 below.

8.1-5 EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.1-6, the executive committee shall act thereon. Such action may include, without limitation, the following recommendations:

(a) No corrective action be taken and, if the executive committee determines that no credible evidence existed for the complaint, the removal of any complaint-related information from the member's file.

(b) Rejection or modification of the proposed corrective action.

(c) Letters of admonition, censure, reprimand or warning, be issued although nothing herein shall be deemed to preclude service chiefs from issuing informal written or oral warnings outside the corrective action mechanism. If such letters are issued the affected member may make a written response that shall be placed in the member's file.

(d) Terms of probation or special limitations be imposed on continued membership or the exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation or monitoring.

(e) Reduction or revocation of clinical privileges.

(f) Suspension of clinical privileges until completion of specific conditions or requirements.

(g) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

(h) Suspension of medical staff membership until completion of specific conditions or requirements.

(i) Revocation of medical staff membership.

(j) Other actions appropriate to the facts which prompted the investigation.

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

8.1-6 DEFERRAL

If additional time is needed to complete the investigative process, the executive committee may defer action on the request for a reasonable period of time, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1-5, Paragraphs (a) through (j) above must be made within the time specified by theexecutive committee, and if no such time is specified, then within thirty (30) days of the referral.

8.1-7 PROCEDURAL RIGHTS

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

8.1-8 OTHER ACTION

(a) If the executive committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the governing body, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-6 (Action by the Governing Body) and 6.3-7 (a) (Notice of Final Decision), as applicable.

(b) If the executive committee's recommended action is an admonition, reprimand or warning to a practitioner, it shall, at the practitioner's request, grant him/her an interviewas provided in Section 8.4. Following the interview, if one is requested, if the executive committee's final recommendation to the governing body is an admonition, reprimand, or warning, this shall conclude the matter when approved

by the governing body without substantial modification, and notice of the final decision shall be given to the governing body, CEO/agent, executive committee, the chief of each service concerned and thepractitioner.

(c) If any proposed corrective action by the governing body will substantially modify the executive committee's recommendation, the governing body shall submit the matter tothe joint conference committee for review and recommendation before making its decision final. Any recommendation of the governing body which constitutes grounds for a hearing as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the CEO/agent shall give the practitioner written notice of the tentative adverse recommendation and of his/her right to request a hearing in the manner specified in Section 9.3-2.

(d) If the governing body should determine that the executive committee has failed to act in timely fashion on the proposed corrective action, the governing body, after notifying the executive committee, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the final decision of the governing body. If such action is one of those set forth in Section 9.2, the CEO/agent shall give the practitioner written notice of the adverse recommendation and of his/her right to request a hearing in the manner specified in Section 9.3-2 and his/her rights shall be as provided in Article IX.

8.2 SUMMARY SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantiallikelihood of imminent impairment of the health or safety of any patient, prospective patient,employee, or other person present in the Hospital, any person or body authorized to initiate proposed corrective action pursuant to Section 8.1-1 hereof shall have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of the practitioner.

Such summary suspension shall become effective immediately upon imposition and the person or body responsible therefore shall promptly give oral or written notice of the suspension to the practitioner, governing body, executive committee and CEO/agent. The notice of the suspension given to the executive committee shall constitute a request for corrective action and the procedures set forth in Section 8.1 shall be followed. In the event of any such suspension, the practitioner's patients whose treatment by such practitioner is terminated by the summary suspension shall

be assigned to another practitioner by the service chief or by the Chief of Staff. The wishes of the patient shall be considered, where possible, in choosing a substitute practitioner.

8.2-2 EXECUTIVE COMMITTEE ACTION

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

8.2-3 PROCEDURAL RIGHTS

Unless the executive committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspensions terminated by the hearing committee. The practitioner shall not be entitled to the procedural rights afforded by Article IX until such time as the executive committee or governing body has taken action pursuant to Sections 8.1-5 through 8.1-8, and then only if the action taken constitutes grounds for a hearing as set forth in Section 9.2.

8.3 AUTOMATIC SUSPENSION

8.3-1 LICENSE

(a) Revocation or Expiration: Whenever a practitioner's or AHP's license authorizing him/her to practice in this state is revoked or has expired pursuant to the rules of the respective licensing board or certifying body, his/her Staff membership, prerogatives and clinical privileges shall be immediately and automatically terminated.

(b) Restriction: Whenever a practitioner's or AHP's license authorizing him/her to practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges which he/she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.

(c) Suspension: Whenever a practitioner's or AHP's license authorizing him/her to practice in this state is suspended, his/her Staff membership and clinical privileges

shall be automatically suspended effective upon, and for at least the term of, the suspension.

(d) Probation: Whenever a practitioner or AHP is placed on probation by the applicable licensing authority, his/her applicable membership status, prerogatives, privileges andresponsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

Practitioners shall not be entitled to the procedural rights afforded by Article IX for any of the action set forth in Section 8.3-1 of these Bylaws.

8.3-2 DRUG ENFORCEMENT ADMINISTRATION

(a) Revocation or Expiration: Whenever a practitioner's DEA certificate is revoked or has expired, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate.

(b) Suspension: Whenever a practitioner's DEA certificate is suspended, he/she shall be divested, at a minimum, of his/her right to prescribe medications covered by the certificate effective upon, and for at least the term of, the suspension.

(c) Probation: Whenever a practitioner's DEA certificate is subject to an order of probation, his/her right to prescribe medications covered by the certificate shall automaticallybecome subject to the terms of the probation effective upon, and for at least the term of,the probation.

Practitioners shall not be entitled to the procedural rights afforded by Article I for any of the actions set forth in Section 8.3-2 of these bylaws.

8.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails, without good cause, to appear and satisfy the requirements of Section 13.7, shall automatically be suspended from exercising all, or such portion of his/her clinical privileges as may be suspended, in accordance with the provisions of said Section.

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

As soon as practicable after action is taken as described in Section 8.3-1, Paragraphs (b), (c) (d) or in Sections 8.3-2 or 8.3-3, the executive committee shall convene to review and

consider the facts upon which such action was predicated. The executive committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it, and/or it may direct that an investigation be undertaken pursuant to Section 8.1-4. The procedure to be followed shall be as provided in Sections 8.1-7 and 8.1-8, as applicable, if the executive committee takes action, or as described in Section 8.1-4 through 8.1-8 if the executive committee directs a further investigation.

8.3-5 MEDICAL RECORDS

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

8.3-6 PROFESSIONAL LIABILITY INSURANCE

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

8.3-7 PROCEDURAL RIGHTS - MEDICAL RECORDS AND PROFESSIONAL LIABILITY INSURANCE

Practitioners or AHP's whose clinical privileges are automatically suspended and/or who have resigned their medical staff membership pursuant to the provisions of 8.3-5 (failure to complete medical records) or 8.3-6 (failure to maintain professional liability insurance) shall be entitled to the procedural rights set forth in Article IX, but the hearing and appeal shall be limited solely to a factual determination of whether the requisite continuous insurance coverage way maintained, or the medical records were timely completed or good cause was shown for their failure to betimely completed.

8.3-8 NOTICE OF AUTOMATIC SUSPENSION: TRANSFER OF PATIENTS

Whenever a practitioner's or AHP's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner or AHP, the executive committee, the CEO/agent and the governing body. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner's patients, whose treatment by such practitioner is terminated by the automatic suspension, shall be assigned to another practitioner by the service chief or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

8.3-9 ENFORCEMENT

It shall be the mutual duty of the chief of the medical staff, the CEO/agent and the governing body to cooperate fully in enforcing all automatic suspensions.

8.4 INTERVIEWS

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

ARTICLE IX: HEARINGS AND APPELLATE REVIEWS

9.1 PREAMBLE AND DEFINITIONS

9.1-1 EXHAUSTION OF REMEDIES

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

9.1-2 DEFINITIONS

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

(a) "Body whose decision prompted the hearing" refers to the Executive Committee or authorized officers, members or committees of the Medical Staff who took the action or rendered the decision which resulted in a hearing being requested, and refers to Governing Body in all cases where the Governing Body or authorized officers, directors or committees of the Governing Body took the action or rendered the decision whichresulted in a hearing being requested.

(b) "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his/her or its address as it appears in the records of the Hospital.

(c) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 9.3 of these Bylaws.

(d) "Date of Receipt" of any notice or other communication shall be deemed to be the date of such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 9.1-2.

9.2 GROUNDS FOR HEARING

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

(a) Denial of medical staff membership.

(b) Denial of requested advancement in staff membership status.

(c) Denial of staff reappointment.

(d) Demotion to lower staff category or membership status.

(e) Suspension of staff membership until completion of specific conditions or requirements.

(f) Summary suspension of staff membership during the pendency of corrective action and hearings and appeals procedures.

(g) Expulsion from staff membership.

(h) Denial of requested privileges (not including temporary privileges).

(i) Reduction in privileges.

(j) Suspension of privileges until completion of specific conditions or requirements.

(k) Summary suspension of privileges during the pendency of corrective action and hearing and appeals procedures.

(l) Termination of privileges (not including temporary privileges).

(m) Requirement of consultation.

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

9.3 REQUEST FOR A HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases where the body which, under these bylaws, has the authority to, and

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

9.3-2 REQUEST FOR HEARING

The petitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing by an ad hoc body. Said request shall be initiated by notice to the Chief of Staff with a copy to the CEO. In the event the petitioner does not request a hearing within thetime and in the manner herein above set forth, he/she shall be deemed to have accepted the recommendation, decision or action involved and it shall thereupon become the final action of the medical staff. Such final recommendation shall be considered by the governing body withinforty-five (45) days, but shall not be binding on the governing body.

9.3-3 TIME AND PLACE FOR HEARING

Upon receiving a request for hearing, the Chief of Staff, within thirty (30) days after the date of receipt of the request, shall schedule and arrange for a hearing. He/she shall give notice to the petitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for a hearing by the Chief of Staff; provided, however, that when the request is received from a petitioner who is under a suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceedthirty (30) days from the date of receipt of the request for hearing by the Chief of Staff.

9.3-4 NOTICE OF CHARGES OR GROUNDS FOR ACTION

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

9.3-5 AD HOC HEARING COMMITTEE/HEARING OFFICER

When a hearing is requested, the Chief of Staff shall appoint an ad hoc hearing committee consisting of at least three (3) members of the medical staff, and alternates as appropriate, or a single hearing officer, or one or more independent practitioner reviewers as may be

necessary or desirable under the circumstances. The members or independent practitioner(s) selected to serve on the hearing committee or the hearing officer shall not have actively participated in the formal consideration of the matter at any previous level and shall not be in direct economic competition with the practitioner requesting the hearing. When the practitioner requesting the hearing is a member of the Dental, Podiatry or Psychology Staff, one member of the hearing committee should be a licensed dentist, podiatrist or psychologist as appropriate. The Chief of Staff shall designate a chairman who shall preside in the manner described in Sections 9.4-1 and 9.4-3 below, and handle all pre-hearing matters and preside until a hearing officer, as described in Section 9.4-4 below is appointed.

9.3-6 FAILURE TO APPEAR

Failure, without good cause, of the petitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved, and it shall thereupon become the final recommendation of the medical staff. Such final recommendation shall be considered by the governing body within forty-five (45) days but shall not be binding on the governing body.

9.3-7 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these bylaws may be requested by an affected person and shall be permitted by the hearing committee or its chairman acting upon its behalf, or by the hearing officer, on a showing of good cause.

9.4 HEARING PROCEDURE

9.4-1 PRE-HEARING PROCEDURE

Each party shall promptly furnish to the other a written list of the names and addresses of the individuals, so far as then reasonably known or anticipated, who may give testimony in support of that party at the hearing. If witnesses are added after the list has been given to the other party, it shall be the duty of that party to notify the other of the change. The failure to timely provide, without good cause, the names of a witness or witnesses shall prevent such witness or witnesses from appearing or testifying at the hearing. Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the hearing officer may confer with both parties to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing.

It shall be the duty of the member and the executive committee, or its designee, to exercise reasonable diligence in notifying the hearing officer or the hearing committee of

any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

The executive committee shall forward to the member a copy of and shall provide access to all evidence on which the charges or reasons are based or will be supplied at the hearing.

9.4-2 REPRESENTATION

Any party, including the practitioner, the executive committee and the governing body, may be represented at the hearing or the appellate review by an attorney at law, provided the party desiring to be so represented, shall give written notice to other party and the hearing committee or governing body, as appropriate, at least fifteen (15) days prior to the commencement of the hearing. In the event that the practitioner does not exercise his/her right to be represented by an attorney at law, the practitioner shall be entitled to be accompanied by and represented only by a practitioner of the same license who is licensed to practice in the State of Iowa. The body whose decision prompted the hearing shall appoint a representative from its membership, who shall present its recommendation, decision or action taken and the materials in support thereof, andmay examine witness. The foregoing shall not be deemed to restrict the right of any party to the assistance or participation of legal counsel in the hearing or appellate review process.

9.4-3 THE PRESIDING OFFICER

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

9.4-4 THE HEARING OFFICER

At the request of the petitioner, the executive committee, the hearing committee, the governing body, the CEO or his/her designee may appoint a hearing officer to preside at the hearing. The hearing officer preferably has experience in medical staff matters and may be an attorney. He/she may not act as a prosecuting officer, as an advocate for the hospital, governing body, executive committee, the body whose action prompted the hearing or the petitioner. If the hearing officer is an attorney, he/she may be requested by the hearing committee to participate in the deliberations of such body and be

a legal advisor to it, but he/she shall not be entitled to vote.

9.4-5 RECORD OF THE HEARING

The hearing committee or hearing officer shall maintain a record of the hearing by a certified shorthand reporter present to make a record of the hearing, or a use of a tape recording of the proceedings, the method to be determined by the committee chair or hearing officer. The cost of any certified shorthand reporter or transcription of the tape recording or reporter's record shall be borne equally by both parties. The hearing committee or hearing officer may, but shall not berequired to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this state or by affirmation under penalty of perjury to the presiding officer.

9.4-6 RIGHTS OF THE PARTIES

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

9.4-7 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her position and the hearing committee or hearing officer may request such a statement to be filed following the conclusion of the presentation of oral testimony. The hearing committee or hearing officer may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

9.4-8 BASIS OF DECISION

If the hearing committee or hearing officer should find the charge(s) to be true, it shall impose such form of discipline as it shall find warranted, including such form of discipline or action that may be more stringent than that recommended by the body whose

decision prompted the hearing. The decision of the hearing committee or hearing officer shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

(1) oral testimony of witnesses;

(2) briefs or written statements presented in connection with the hearing.

(3) any material contained in the hospital or medical staff personnel files regarding the petitioner which shall have been made a party of the hearing record;

(4) any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record;

(5) any other evidence admissible hereunder.

9.4-9 BURDEN OF GOING FORWARD AND BURDEN OF PROOF

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

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

9.4-10 ADJOURNMENT AND CONCLUSION

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The hearing committee or hearing officer shall thereupon, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report.

9.4-11 DECISION OF THE HEARING COMMITTEE/HEARING OFFICER

Within fifteen (15) days after final adjournment of the hearing (provided that in the event the petitioner is currently under suspension, this time shall be ten (10) days), the hearing committee or hearing officer shall render a decision which shall be accompanied by a written report that contains findings of fact, which shall be in sufficient detail to enable the parties, any appellate review board, and the governing body to determine the basis for the hearing committee's or hearing officer's decision on each matter contained in the notice of changes. The decision and report shall be delivered to the executive committee, the CEO and the governing body. At the same time, a copy of the report and decision shall be delivered to the petitioner by registered or certified mail, return receipt requested. The decision of the hearing committee or hearing officer shall be considered final, subject only to the right of appeal to the governing body as provided in Section 9.5

9.5 APPEALS TO THE GOVERNING BODY

9.5-1 TIME FOR APPEAL

Within thirty (30) days after the date of receipt of the hearing committee or hearing officer's decision, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the governing body. Said request shall be delivered to the CEO in writing either in person or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the medical staff. Such final recommendation shall be considered by the governing body within forty-five (45) days, but shall not be binding on the governing body.

9.5-2 GROUNDS FOR APPEAL

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

(a) substantial noncompliance with the procedures required by these bylaws or applicable law so as to deny a fair hearing;

(b) the decision was not supplied by substantial evidence based on the hearing record

or such additional information as may be permitted pursuant to Section 9.5-5; or

(c) action taken arbitrarily, unreasonable or capriciously.

9.5-3 TIME, PLACE AND NOTICE

When appellate review is requested pursuant to the preceding subsection, the governing body shall, within thirty (30) days after the date of receipt of such an appeal notice, schedule andarrange for an appellate review. The governing body shall give the petitioner notice of the time, place and date of the appellate review. The date of appellate review shall not be less than fifteen (15) or more than sixty (60) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the governing body or appeal board (if any).

9.5-4 APPEAL BOARD

When an appellate review is requested, the governing body shall act as the reviewing panel. At least four (4) Trustees shall be present for and consider the practitioner's appeal. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decisionto recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

9.5-5 HEARING PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee or hearing officer, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing committee or hearing officer in theexercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the appeal board may remand the matter to the hearingcommittee or hearing officer for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his/her position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear andmake oral argument.

At the conclusion of oral argument, if allowed, the appeal board may thereupon

conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. If an appeal board is appointed, the appeal board shall present to the governing body its written recommendations as to whether the governing body should affirm, modify or reverse the hearing committee or hearing officer's decision, or remand the matter to the hearing committee or hearing officer for further review and decision. If no appeal board is appointed, the procedures outlined in the subsection shall apply to a hearing before the governing body.

9.5-6 DECISION

Within fifteen (15) days after the conclusion of the appellate review proceedings, the governing body shall render a final decision in writing. The governing body may affirm, modify or reverse the hearing committee or hearing officer decision, or, in its discretion, remand the matter for further review and recommendation by the hearing committee or hearing officer or any other body or person. Copies of the decision shall be delivered to the petitioner and to the executive committee, by personal delivery or by certified or registered mail, return receipt requested. If the decision is in accordance with the executive committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to fu1iher hearing or appellate review. If the decision is contrary to the executive committee's last such recommendation, the governing body shall refer the matter to the joint conference committee for fu1iher review and recommendation, and shall include in such notice of its decision a statement that a final decision will not be made until the recommendations of the joint conference committee have been considered.

9.5-7 FURTHER REVIEW

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

9.5-8 RIGHT TO ONE HEARING

Notwithstanding any other provision of these bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the executive committee or the governing body or by both.

9.5-9M MANDATORY REPORTING

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

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS AND MEDICO- ADMINISTRATIVE OFFICES

(a) Closed Staff or Exclusive Use Departments: The fair hearing rights of Articles VIII and IX do not apply to a practitioner whose application for medical staff membership and privileges was denied on the basis the privileges he/she seeks are granted only pursuant to a closed staff or exclusive use policy. Such practitioners shall have the right, however, to request that the governing body review the denial, and the governing body 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/her position to the governing body.

(b) Medico-Administrative Officers. The fair hearing rights of Articles VIII and IX do not apply to those persons serving the hospital in a medico-administrative capacity. Such persons shall instead be governed by the provisions of these bylaws specific to medico-administrative officers and by the terms of their individual contracts and agreements with the hospital. However, the hearing rights of the preceding sections of this Article IX and of Article VII shall apply to the extent that medical staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

9.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

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

ARTICLE X: OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The officers of the medical staff shall be:

1) Chief of Staff (chair)

2) Vice-Chief of Staff (vice-chair)

3) Secretary

10.1-2 QUALIFICATIONS

Officers must be practitioner members in good standing of the active medical staff at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 ELECTION OF OFFICERS

Officers shall be elected at the annual meeting of the medical staff. Only members of the active medical staff shall be eligible to vote. Voting shall be done orally or by secretwritten ballot. The nominating committee shall offer one or more candidates for each office. The committee shall be appointed by the Chief of Staff and shall consist of members of the active medical staff. Nominations may also be made from the floor at the annual meeting.

A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the executive committee at its next meeting or a special meeting called for that purpose shall decide the election. This voteshall be by secret written ballot.

10.1-4 TERM OF OFFICE

All officers shall serve a one (1) year term commencing on the first day of the medical staff year(or on some other specified date) following their election. Each officer shall serve until the endof his/her term and until a successor is elected, unless he/she shall

sooner resign or be removedfrom office.

10.1-5 REMOVAL OF ELECTED OFFICERS

Except as otherwise provided in these bylaws, removal of an officer may be initiated by the executive committee or upon the written request of twenty-percent (20%), but not less than two, of the members eligible to vote for officers. Such removal may be effected by a majority vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be bysecret written mail ballot. The written ballots shall be sent to each voting member at least ten (10) days before the voting date and the ballots shall be counted by the Executive Committee of the medical staff (except when he/she is the subject of the balloting, in which case the CEO/Agent shall count the ballots). Removal shall be effective upon the approval of the hospital governing body.

If an officer ceases to be a member in good standing of the active medical staff, or loses a contract or employment relationship with the hospital or suffers a loss or significant limitation of practice privileges, that member shall be removed by the executive committee.

10.1-6 VACANCIES IN ELECTED OFFICE

Vacancies in office, except for the Chief of Staff, shall be filled by the executive committee at a regular or special meeting. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term and then serve as Chief of Staff for the following full term.

10.2 DUTIES OF OFFICERS

10.2-1 CHIEF OF STAFF (CHAIR)

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

1) act in coordination and cooperation with the CEO and governing body in all matters of mutual concern within the hospital;

2) call, preside at and be responsible for the agenda of all general meetings of the medical staff;

3) serve as chair of the medical staff executive committee;

4) serve as an ex officio member of all other medical staff committees without vote unless his/her membership in a particular committee is required by these bylaws;

5) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

6) appoint committee members to all standing, special and multi-disciplinary medical staff committees, except the executive committee;

7) to be the spokesperson for the medical staff in its external professional and public relations;

8) be responsible for the educational activities of the medical staff;

9) serve as a liaison representative between the medical staff and governing body representing the views, policies, needs and grievances of the medical staff to the governing body and to the CEO, and interpreting the policies of the governing body tothe medical staff; and

10) perform such other functions as may be assigned to him/her by these bylaws, by the membership, by the executive committee or by the governing body.

10.2-2 VICE-CHIEF OF STAFF (VICE-CHAIR)

In the absence of the Chief of Staff, the Vice-Chief of Staff shall assume all duties and the authority of the chief. The vice-chief shall be a member of the executive committee and the joint conference committee, shall perform such other supervisory duties as the president may assign and shall carry out such other functions as may be delegated to him/her by these Bylaws by the membership, by the executive committee, or by the governing body. The vice-chief shall automatically succeed the chief when the latter fails to serve for any reason.

10.2-3 SECRETARY

The Secretary shall be a member of the executive committee, maintain a roster of members, keep accurate and complete minutes of all executive committee and medical staff meetings, call meetings on order of the Chief of Staff, attend to all correspondence and perform such other duties as ordinarily pertain to his/her office or as may be assigned to him/her.

ARTICLE XI: CLINICAL SERVICES

11.1 ORGANIZATION OF SERVICES

There shall be services of medicine, surgery, obstetrics and such other services as the size and degree of specialization of the active medical staff may warrant. Each service may be headed by a chief of service or may function under the executive committee.

11.2 SERVICE CHIEF

11.2-1 QUALIFICATIONS

Each chief shall be a member of the active medical staff and a member of the service which he/she is to head, shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the service, and shall be willing and able to discharge the administrative responsibilities of his/her office.

11.2-2 SELECTION

The Chief of Staff, subject to the approval of the executive committee and the governing body, shall appoint each chief.

11.2-3 TERM OF OFFICE

Each chief shall serve a one-year term, commencing on his/her appointment. He/she shall serve until the end of the succeeding medical staff year and until his/her successor is chosen, unless he/she shall sooner resign or be removed from office. A chief may be removed by a majority vote of the governing body or of the executive committee with the approval of the governing body.

11.2-4 DUTIES

Each chief shall:

A) be accountable to the executive committee for all the effective operation of his/her service;

B) develop and implement, in cooperation with other members of his/her service, programs to carry out the quality review, evaluation and monitoring functions assigned to his/her service; and report regularly thereon to the executive committee;

C) exercise general supervision over all clinical work performed within his/her service;

D) be responsible for implementation within his/her service of actions taken by the executive committee or the medical staff;

E) conduct investigations and submit reports and recommendations to the executive committee concerning the appointment or reappointment and the clinical privileges to be exercised by all practitioners and AHP's applying for or practicing in his/her service;

F) assist in the teaching, education and research program in his/her service;

G) act as presiding officer at all service meetings;

H) assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her service as may be required by the executive committee, the CEO or the governing body; and

I) perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the executive committee or the governing body.

11.3 FUNCTIONS OF SERVICES

A) Conduct patient care reviews for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients within the service. The number of such reviews to be conducted during the year shall be as determined by the executive committee and shall be conducted in accordance with such procedures as may be adopted by the Quality Assurance/Infection Prevention Committee. Each service shall review all clinical work performed under its jurisdiction, whether or not the particular person whose work is subject to such review is a member of that service. The criteria to be used in such review shall be objective and reflect current knowledge and clinical experience. Each service shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of action that has been taken in such problems. If surgical procedures are performed in the service, the service shall review, on a monthly basis, ~~all~~ 10% of surgical cases regardless of whether a tissue or non-tissue specimen was removed. The executive committee may assign certain case review responsibilities to the Quality Assurance Committee. See

"Committees" within each service.

B) Submit reports to the executive committee and medical staff concerning: (1) findings of the service's review, evaluation and monitoring activities, acts taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the service in the hospital. If such reports are oral, a written summary of the oral report shall be prepared;

C) Meet at least quarterly for the purpose of receiving, reviewing and considering patient care review findings and the results of the service's other review, evaluation and monitoring activities and for the performance or reception of reports on other service and staff functions.

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

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

F) Monitor, on a continuing and concurrent basis, adherence to: (1) medical staff and hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; and (4) fire and other regulationsdesigned to promote patient safety.

G) Coordinate the patient care provided by the service's members with nursing and ancillary patient care services and with administrative support services.

H) Establish such committees and other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

11.4 ASSIGNMENT OF SERVICES

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

ARTICLE XII: COMMITTEES

12.1 GENERAL

12.1-1 DESIGNATION

The committees described in this Article shall be the standing committees of the medical staff. Unless otherwise specified, the members of such committees and the chair of such committeesshall be appointed by the Chief of Staff, subject to the approval of the medical staff, and suchcommittees shall be responsible to the medical staff. Unless membership on a committee isotherwise specified in these bylaws, the Chief of Staff may appoint representatives of hospital management, nursing service, health information systems, pharmacy and other hospital departments or services as may be necessary or desirable. The CEO may attend any meetingsof any medical staff committees at the discretion of the committee chair, the governing body or the CEO/agent, unless his/her membership on a committee is expressly required in these bylaws. Unless otherwise specified, the CEO/agent's participation shall be ex officio without vote.

Committees to perform specified tasks may be created by the Chief of Staff with the approval of the medical staff ad hoc. Such committees shall terminate at the end of the medical staff year unless they are renewed by the executive committee. The members of special committees shall also be appointed by the Chief of Staff, subject to the approval of the medical staff.

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

(a) A named committee, but no such committee exists, the executive committee shall perform such function or receive such report or recommendation or shall assign the functions of such committee to a new or existing committee of the medical staff or to thestaff as a whole.

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

The functions of any or all committees may be carried out by the medical staff as a whole, unless otherwise specified in these bylaws.

12.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of one (1) year, and shall serve until the end of this period and until his/her successor is appointed, unless he/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 staff. The removal of any committee member who is automatically assigned to a Committee because he/she is a general officer or medico-administrative officer shall be governed by the provisions pertaining to removal of such officers.

12.1-3 VACANCIES

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

12.1-4 CONDUCT AND RECORDS OF MEETINGS

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

12.1-5 VOTING

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

12.1-6 PRIVILEGE AND CONFIDENTIALITY

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

12.2 EXECUTIVE COMMITTEE

12.2.1 COMPOSITION

The executive committee shall consist of the Chief of Staff, the Vice-Chief of Staff, and the Chief Medical Officer. The CEO of the hospital shall be an ex officio member, without vote. Except for credentialing and corrective action, the functions of the executive committee may be carried out by the medical

staff as a whole.

12.2-2 DUTIES

The duties of the executive committee shall be to:

A) represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

B) coordinate the activities and general policies of the medical staff not otherwise established as the responsibility of the services;

C) receive and act upon service and committee reports, and refer cases to the active staff if this is considered necessary or desirable;

D) require consultation on cases when it is deemed necessary or desirable;

E) implement policies of the medical staff not otherwise the responsibility of the services;

F) recommend action to the CEO on matters of a medico-administrative nature;

G) fulfill the medical staff's accountability to the governing body for the medical care rendered to patients in the hospital;

H) review the credentials of applicants and make recommendations for staff membership, assignments to services and delineation of clinical privileges;

I) review periodically all information available regarding the performance and clinical competence of staff members, other practitioners and AHP' s with clinical privileges and, as a result of such reviews, make recommendations for reappointments and renewals or changes in clinical or practice privileges;

J) take all reasonable steps to ensure professionally ethical conduct on the part of all practitioners and AHP' s, including the initiation of and/or participation in medical staff connective or review measures when warranted;

K) report at each general staff meeting;

L) perform such other functions as may be assigned to it by these bylaws, by

the medical staff or by the governing body;

M) conduct an annual review of The Medical Staff Bylaws, Rules and Regulations; receive comments and recommendations regarding these matters from the medical staff, thepresident, the services, the governing body and the CEO; and submit recommendationsto the medical staff and the governing body for changes in these documents;

N) foster effective communications with the governing body, one or more members will attend most regular meetings of the governing body.

12.2-3 MEETINGS

The executive committee shall meet once a month or as needed, and shall maintain a record of its proceedings and actions.

12.3 QUALITY IMPROVEMENT/INFECTION CONTROL COUNCIL

12.3-1 COMPOSITION

The quality improvement/infection control council shall consist of at least one provider from the medical staff, hospital CEO/agent, and representatives from hospital departments on a rotating basis when requested or considered necessary or desirable.

12.3-2 DUTIES

The quality assurance/infection prevention committee shall be responsible for:

(a) adopting, subject to medical staff and governing body approval, a quality management plan which sets forth specific programs and procedures for reviewing, evaluating and maintaining the quality and efficiency of patient care within the hospital on a hospital-wide basis. The plan may include mechanisms for:

(1) establishing objective criteria; (2) measuring actual practice against the criteria; (3) analyzing practice variations from criteria by peers; (4) taking appropriate action to correct identified problems; (5) following up on action taken; and (6) reporting the findings and results of the audit activity to the medical staff, the CEO and the governing body. The quality assurance plan shall be considered a part of the bylaws, rules and regulations of the staff.

(b) reviewing and acting upon, on a regular basis, factors affecting the quality and efficiency of patient care and the protection of patient rights in the hospital.

(c) coordinating the findings and results of service, committee and staff patient care audit activities, and other staff activities desired to monitor patient care practices.

(d) submitting reports to the medical staff on the overall quality and efficiency of medical care provided in the hospital, patient care audit, and other quality review, evaluation andmonitoring activities.

(e) developing and maintaining methods for the protection and care of the hospital patients and others at time of internal and external disaster. Specifically, it shall:

(1) adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least four times a year;

(2) adopt and periodically review a plan for the care, reception and evacuation of mass casualties, and shall assure that such plan is coordinated with the inpatient and outpatient services of the hospital, community services, and the anticipated role of the hospital in the event of disasters in nearby communities. The plan is rehearsedby key personnel at least twice yearly.

(f) making recommendations for the development of appropriate educational programs;

(g) developing a hospital-wide infection control program and maintaining surveillance over the program;

(h) developing a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action;

(i) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques. Such

techniques shall be defined in written policies and procedures;

(j) developing written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered;

(k) developing, evaluating and revising preventive, surveillance and control policies and procedures relating to all phases of the hospital's activities, including: operating rooms, special care units, central service, dietetic service, housekeeping, maintenance and laundry, sterilization and disinfection procedures by heat, chemicals, or otherwise, isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment, testing of hospital personnel for carrier status, disposal of infectious material, food sanitation, waste management, and other situations as requested;

(l) acting upon recommendations related to infection control from the president, the executive committee, the services and other medical staff and hospital committees;

(m) establishing an incident reporting system that includes a mechanism for investigating and evaluating all incidents reported;

(n) providing guidance for orientation and continuing education of all employees in safety and infection control practices.

Infection control activities shall be undertaken for the purpose of reducing morbidity and mortality, and all data, documents, reports, and records related thereto shall be privileged and confidential pursuant to Iowa law.

12.3-3 MEETINGS

The quality assurance/infection control committee shall meet once a month and shall transmit written reports of its activities and recommendations to the executive committee and/or the active medical staff and to the governing body.

12.4 UTILIZATION REVIEW COMMITTEE

12.4-1 COMPOSITION

The utilization review committee shall consist of at least one provider member of the medical staff by condition of participation and at least three other representatives of the hospital who shall be representative of the various areas encompassed within the scope of the committee's work. The pathologist shall serve as an ex officio member, with vote.

12.4-2 DUTIES

The utilization review committee shall be responsible for:

(a) reviewing and evaluating medical records to determine whether; (1) they properly describe the condition and progress of the patient, the therapy provided, and results thereof and provide adequate identification and records of individual responsibility for all actions taken; (2) they are sufficiently complete at all times to facilitate continuity of care and communications between all individuals providing patient care services in the hospital; and (3) psychiatric or substance abuse records include special justification for the use of restraint or seclusion, electro convulsive shock therapy, other forms of conclusive therapy, psycho surgery, behavior modification procedures that use adverse conditioning and other special treatment procedures for children and adolescents, as required by Iowa law and applicable authorities.

(b) monitoring and evaluating the following functions:

(1) Surgical Review: Monthly review of 10% of surgical matters, which shall include a comprehensive review for justifiability of surgery performed whether tissue was removed or not, for acceptability of the procedure chosen and for agreement or disagreement between the preoperative, postoperative and pathological diagnosis. Such review shall be undertaken for the purpose of reducing morbidity and mortality, and all data, documents, reports and records related thereto shall be strictly confidential.

(2) Surgical Antibiotic Usage Review: Ongoing review of prophylactic and therapeutic use of antibiotics for inpatients and emergency patients. Criteria for use in problem areas shall be established and deviations

reviewed.

(3) Blood Utilization Review: Quarterly review of blood transfusions for proper utilization, to include the use of whole blood vs. components, evaluation and reporting of each actual or suspected reaction, and review of the amount of blood requested, the amount used and the amount of wastage.

(c) reviewing Medical Staff and Hospital Policies and Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein;

(d) acting upon recommendations from the medical staff, executive committee, the services and other committees responsible for patient care audit and other quality review, evaluation and monitoring functions;

(e) providing liaison with hospital administration and the medical records professionals employed by the hospital on matters relating to medical records practices;

(f) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of hospital and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the services affects the quality of patient care provided at the hospital, shall study patterns of care and develop and designate standards relating to average or normal lengths of stay by specific disease categories, and evaluate systems of utilization review employing such standards. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate date on the availability of other suitable health care facilities and services outside the hospital. The committee shall communicate the results of its studies and other pertinent data to the entire medical staff and shall make recommendations for the utilization of hospital resources and facilities commensurate with quality patient care and safety;

(g) formulating and following a written utilization review plan for the hospital. Such plan, which shall be approved by the medical staff and the governing body, shall include all of the following elements:

1) the organization and composition of committee(s) which will be responsible for the utilization review function;

2) frequency of meetings;

3) the types of records to be kept;

4) the method to be used in selecting cases on a sample or other basis;

5) the definition of what constitutes the period of extended duration;

6) the relationship of the utilization review plan to claims administration by a third party;

7) arrangements for committee reports and their dissemination; and

8) responsibilities of the hospital's administrative staff in support of utilization review.

(h) evaluating the medical necessity for continued hospital services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

1) no practitioner shall have review responsibility for any extended stay cases in which he/she was professionally involved.

2) all decisions that further inpatient stay as not medically necessary shall be made by practitioner members of the committee and only after opportunity for consultation has been given the attending practitioner by the committee and full consideration has been given to the availability of out-of-hospital facilities and services.

3) where there is significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending practitioner shall be given great weight.

4) all decisions that further inpatient stay is not medically necessary shall be given by written notice to the executive committee, to the chief of the appropriate service, to the CEO and to the attending practitioner for such action, if any, as may be warranted.

12.4-3 MEETINGS

The committee shall meet at least quarterly and more frequently as needed and shall maintain a record of its proceedings and actions.

12.5 PHARMACY AND THERAPEUTICS COMMITTEE

12.5-1 COMPOSITION

Membership shall consist of at least one representative of the medical staff and one each from the pharmaceutical service, the nursing service and hospital administration. The hospital pharmacist shall be a voting member of and act as secretary for the committee.

12.5-2 DUTIES

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

(a) serve as an advisory group to the medical staff and the pharmacist on matters pertaining to choice of available drugs;

(b) make recommendations concerning drugs to be stocked on the nursing units and by other services;

(c) utilize a formulary or drug list, and periodically review and update the formulary or list;

(d) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(e) evaluate clinical data concerning new drugs or preparations requested for use in the hospital; and

(f) establish standards concerning the use and control of investigational

drugs and of research in the use of recognized drugs.

12.5-3 MEETINGS

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

12.6 OTHER

All other committee functions not specified above shall be the responsibility of the executive committee or the medical staff as a whole. The chief of the medical staff shall also be authorized to appoint such other committees as shall from time to time be deemed necessary or desirable. Such committees shall confine their work to the purpose for which they were created and shall report to the full medical staff unless otherwise specified. Special committees shall not have power to act unless the motion that created the committee specifically grants such power.

ARTICLE XIII: MEETINGS

13.1 MEETINGS

13.1 ANNUAL MEETING

The annual meeting of the medical staff shall be the last regular meeting before the end of the calendar year. At this meeting, the retiring officers and committees shall make such reports as may be required, officers for the ensuing year shall be elected, and the Chief of Staff shall present a report on actions taken during the year and on other matters believed to be of interest to the membership.

13.2 REGULAR MEETINGS

The medical staff will meet at least a minimum of nine times per year with the last meeting of the calendar year serving as the annual meeting.

The medical staff shall, by standing resolution, designate the date, time and place for all regular staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the staff in the same manner as provided in SECTION 13.1-2 of this ARTICLE XIII for notice of a special meeting.

13.3 ORDER OF BUSINESS

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at a minimum:

A. Business

(1) Call to order

(2) Approval of the minutes of the last regular and all special meetings

(3) Committee reports

(4) Program

(5) CEO report

(6) Old business

(7) New business

13.4 SPECIAL MEETINGS

A. Special meetings of the medical staff may be called at any time by the Chief of Staff and shall be called at the request of the governing body or by request of at least one-half, but not less than two (2), members of the active medical staff; the meeting shall be scheduled within seven (7) days of such request. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Written notice shall be distributed to each physician and posted on the bulletin board in the medical staff dictation room at least seventy-two (72) hours prior to the time of the meeting. The attendance of a member of the medical staff at a special meeting shall constitute waiver of notice of such meeting.

B. The agenda at special meeting shall be:

1) Reading of the notice calling the meeting.

2) Transaction of business for which the meeting was called; and

3) Adjournment.

13.2 QUORUM

The presence of fifty percent (50%) of the total membership of the active medical staff at any regular or special meeting shall constitute a quorum

13.3 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. No proxy voting and no cumulative voting shall be permitted. Committee action may be conducted by telephone conference that shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Action may be taken without a meeting by a department, committee or the executive committee by a writing setting forth the action so taken signed byeach member

entitled to vote threat.

13.4 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 and forwarded to the executive committee.) Each committee and service shall maintain a permanent file of the minutes of each meeting.

13.5 ATTENDANCE REQUIREMENTS

13.5-1 GENERAL

A. Each member of the active staff shall be required to attend the annual meeting of the medical staff, and at least fifty percent (50%) of all other regular medical staff meetings in each year. Unless excused for good cause, failure to meet the annual attendance requirements, or unexcused absence from three (3) consecutive regular meetings shall be grounds for any of the corrective actions specified in Section 8.1- 5.

B. Reinstatement to the active medical staff of members whose membership has been revoked because of absences from meetings may be made on application, the procedure being the same as in applications for original appointment.

C. Meeting attendance by members of the honorary, courtesy and associate staffs generally shall not be required, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

13.5-2 REQUIRED ATTENDANCE FOR CASE PRESENTATION

A. At the discretion of the chair or presiding officer, when a member's clinical practice or conduct is scheduled for discussion at a regular service or committee meeting, the member may be requested to attend. If such practitioner is not otherwise required to attend the regular monthly staff meeting, the Chief of Staff shall so inform the CEO who shall give the practitioner advance written notice of the day, time and place of the meeting at which his/her attendance is expected. When apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state, shall be given

by certified mail, return receipt requested, and shall include a statement that his/her attendance at the meeting at which the apparent or suspected deviation is to be discussed is mandatory.

B. Failure by a practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Chief of Staff or his/her designee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the executive committee may direct, and such suspension shall remain in effect until the matter is resolved by subsequent action of the executive committee, as provided in Section 8.3-3.

If the Chief of Staff is the practitioner involved, the executive committee shall consider his/her excuse for good cause. If the practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the Chief of Staff, or by the executive committee if the Chief of Staff is the practitioner involved, until not later than the next regular staff meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

13.6 COMMITTEE AND SERVICE MEETINGS

13.6-1 REGULAR MEETINGS

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

13.6-2 SPECIAL MEETINGS

A special meeting of any committee or service may be called by or at the request of the chairman or chief thereof, by the chief of medical staff, the executive committee or by one- third of the group's then members, but not less than two members.

13.6-3 NOTICE OF MEETINGS

Written or verbal notice of the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each

member of the committee of service not less than seventy-two (72) hours before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States Mail addressed to the member at his/heraddress as it appears on the records of the hospital. The attendance of a member at a meetingshall constitute a waiver of notice of such meeting.

13.6-4 QUORUM

A quorum of fifty percent (50%) of the voting membership shall be required at executive committee meetings. For other committees and services; a quorum shall consist of one-third(1/3) of the voting members but in no event less than one voting member who shall be a physician.

13.6-5 EX OFFICIO MEMBERS

Persons serving under these bylaws as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of quorum and shall not be entitled to vote.

13.6-6 ATTENDANCE

Each committee or service member shall be required to attend not less than fifty percent (50%) of all meetings of his/her committees or services in each year. The reason provided for any absences and the action of the committee chairman or service chief thereon shall be shown in the minutes. The failure to meet the foregoing annual attendance requirements, unless excused by the committee chairman for good cause shown, shall be grounds for any of the corrective actions specified in Section 8.1-5, including, in addition, removal from a committee or service. Committee chairmen and service chiefs shall report such failures to the executive committeefor action. Attendance at committee and service meetings shall apply to all persons assigned to committees and services, whether members of active, courtesy, staff or associate staff or AHP'S.

13.7 CONDUCT OF MEETINGS

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

ARTICLE XIV: CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

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

(a) INFORMATION means all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures, whether in written, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might directlyor indirectly affect patient care.

(b) ALLIED HEALTH PRACTITIONER means a practitioner or an allied health professional.

(c) REPRESENTATIVE means a board, any trustee, a committee, a chief executive officer or administrator of a hospital or other health care institution or their designee, a medical staff entity, an organization of health practitioners, a PRO, a state or local board of medical or professional quality assurance and any members, officer, department, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

(d) THIRD PARTIES mean both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

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

(a) authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing, or reasonably believed to bear, on his/her professionalability and qualifications.

(b) authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitionerto the hospital and its medical staff.

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

(d) acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of medical staff membership and the continuation of such membership or to his/her exercise of clinical privileges at this hospital, or to his/her application for or acceptance of approval and exercise of practice privileges at this hospital.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any health practitioner submitted, collected or prepared by any representative for the purpose of achieving and maintaining quality patient care, evaluating the competency of a practitioner, reducing morbidity and mortality, or contributing to clinical research, shall be privileged and confidential to the fullest extent permitted by law, and shall not be disseminated to anyone other than a representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the medical staff committee files and shall not become part of a particular patient's file or of the general hospital records.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

Each representative of the hospital, including its medical staff members, shall be exempt, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/herduties as a representative.

14.4-2 FOR PROVIDING INFORMATION

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

14.5 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) applications for appointment, reappointment, clinical privileges, practice privileges and prerogatives and periodic reappraisals of a health practitioner's membership, privileges and/or prerogatives;

(b) corrective action;

(c) hearing and appellate reviews;

(d) hospital, service, committee or other medical staff activities related to monitoring, maintaining and improving the quality of patient care, appropriate utilization and appropriate professional conduct;

(e) State Quality Review;

(f) Peer Review.

14.6 RELEASES

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

ARTICLE XV

15.1 RULES AND REGULATIONS

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner and AHP in the hospital. Such rules and regulations shall be a part of these bylaws. The rules and regulations may be amended or repealed at any regular or special meeting at which a quorum is present, following notice at a regular or special meeting and referral to a special committee that shall report at the next regular or special meeting. A simple majority vote of the active medical staff members present shall be required to adopt approval by the governing body. If a conflict arises between the bylaws and the rules and regulations, the bylaws shall prevail.

15.1-2 SERVICE RULES AND REGULATIONS

Subject to the approval of the executive committee or the medical staff and the governing body, each service shall formulate its own rules and regulations for the conduct of its affairsand the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, the general rules and regulations of the medical staff, or other policies of the hospital.

15.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner and AHP shall be required, as a prior condition of initial appointment and reappointment and/or the granting or continued exercise of privileges, to present a current certificate of insurance, from an insurance company licensed or approved by the commissioner of insurance to do business in the State of Iowa, verifying professional liability insurance coverage of at least $1,000,000 per claim and $3,000,000 aggregate or such greater amount as required by the Governing Body, per medical incident. Each member shall report any reduction, restriction, cancellation or termination of the required professional liability insurance coverage or change in insurance carrier as soon as reasonably practical to do so to the CEO and the executive committee.

15.3 CONSTRUCTION OF TERMS AND HEADINGS

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

15.4 AUTHORITY TO ACT

Action of the medical staff in relation to any person other than the members thereof shall be expressed only through the president or the executive committee or his/her or its designee, and they shall first confer with the CEO. Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the executive committee, the medical staff or governing body may deem necessary.

15.5 ACCEPTANCE OF PRINCIPLES

All members of each class or category, by application for membership in this medical staff, dothereby agree to be bound by the provisions of these bylaws as they now exist and may be amended from time to time, a copy of which shall be delivered or made available to each member on his/her initial appointment and throughout the duration of his/her membership onthe staff. Any violation of these bylaws shall subject the applicant or member to such disciplinary action as the executive committee or governing body shall direct.

15.6 DIVISION OF FEES

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

15.7 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first class postage prepaid, certified or registered return, receipt requested. In the case of notice to hospital, governing body, medical

staff or officers of committee thereof, the notice shall be addressed as follows.

Chief Executive Officer
Wayne County Hospital
417 South East Street
P.O. Box 305
Corydon, Iowa 50060

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

ARTICLE XVI: ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

16.1-1 INITIATED BY MEDICAL STAFF

On the request of the Chief of Staff or the medical executive committee, or on timely written petition signed by at least one-third, but not less than two, of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment or repeal of these bylaws. This action shall be taken at a regular or special meeting, provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff and these changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken including notice that a bylaws change would be considered.

16.1-2 INITIATED BY GOVERNING BODY

If these bylaws are not in compliance with the requirements imposed by law, regulation, order of court of law, for accreditation, for tax purposes, or are otherwise reasonably necessary toavoid adverse action or sanction against the hospital, the governing body may request appropriate amendment. The medical staff shall take action on that amendment at its nextregular meeting, following requisite notice, unless sanctions will be imposed upon the hospital in the absence of amendment prior to the next regular meeting, in which case a special meetingof the medical staff shall be called within a reasonable time to act thereon. Such amendment as is proposed by the governing body that is necessary to comply with law, regulation, order of a court of law, accreditation or necessary to avoid adverse action or sanction, shall be deemed adopted by the medical staff unless the medical staff takes action that amends these bylaws to conform to such requirements.

16.2 ACTION ON BYLAWS CHANGE

If a quorum is present for the purpose of enacting a bylaws change, the change shall require an affirmative vote of a simple majority of the members voting in person or by written ballot.

16.3 APPROVAL

Bylaws changes adopted by the medical staff shall become effective following approval by the governing body or automatically within 90 days if no action is taken by the governing body.

Revisions to Bylaws were presented for first reading on June 9, 2016, and second reading on July 12, 2016.

ADOPTED by the Medical Staff on July 12, 2016

_____

Chief of Staff

_____

Secretary

APPROVED by the Board of Trustees on _____

_____

Board of Trustees Chair

_____

Board of Trustees Secretary