Auburn Regional Medical Center

Medical Staff Bylaws

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AUBURN REGIONAL MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

Whereas Auburn Regional Medical Center is a corporation organized under the laws of the State of Washington, and recognizing that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the best interests of the patients are protected by the concerted effort and cooperation on the part of the Medical Staff, the Managing Director, and the Governing Body, the physicians and oral surgeons practicing at Auburn Regional Medical Center do hereby organize themselves in conformity with these Bylaws, Rules and Regulations. The Medical Staff shall regulate itself by these Bylaws, Rules and Regulations, which shall reflect current practice, shall be enforced, and shall be reviewed annually and revised as necessary. The pronouns he/his are understood to apply to the feminine gender, where appropriate.

DEFINITIONS

Clinical Privileges - the rights granted as a particular benefit, advantage or favor to perform specific acts within the practice of medicine or dentistry as clearly delineated by the various medical staff departments.

Credentialing - the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in the Hospital.

Governing Body - the Board of Trustees of the Hospital, or the Executive Committee of the Board acting on its behalf.

Hospital - Auburn Regional Medical Center.

Mail Vote - ballots distributed to the doctors' mail slots in the Hospital mail room or sent to the practitioner's office address.

Managing Director - the Chief Executive Officer appointed by the Governing Body to act on its behalf in the overall management of the Hospital.

Medical Staff - all physicians and oral surgeons who are privileged to attend patients at Auburn Regional Medical Center.

Medical Executive Committee – Medical Staff Executive Committee (MEC)/Executive Committee of the Medical Staff.

Medical Staff Year - January 1 through December 31. The biennial meeting shall be in December.

Oral Surgeon – a dentist who has successfully completed an approved residency in oral and maxillofacial surgery.

Quorum - at least one-third of the membership of the Active Staff or of any of its committees.

Physician - an appropriately licensed doctor of medicine or doctor of osteopathy.

Practitioner – an individual permitted by the Hospital, and by law, to provide care and services consistent with individually granted privileges.

Staff Membership - the state or status of being one of the individuals composing the Medical Staff.

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of Auburn Regional Medical Center.

ARTICLE II

PURPOSES

2.1 Purposes

2.1.1 The Medical Staff Organization shall assure that each member is qualified for membership, and shall strive to maintain the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges and the periodic reappraisal of each staff member.

2.1.2 To monitor the quality and appropriateness of care provided to all patients treated in the hospital.

2.1.3 To make recommendations to the Governing Body regarding appointment and reappointment to the Medical Staff and the granting or renewing of clinical privileges.

2.1.4 To assure a high level of professional performance by all members authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each member may exercise in the Hospital and through an ongoing review and evaluation of each member's performance in the Hospital.

2.1.5 To promote and provide continuing education that will lead to advancement in professional excellence.

2.1.6 To provide Rules and Regulations for self-governance of the Medical Staff.

2.1.7 To provide means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the Administration.

2.1.8 To assure Medical Staff representation and participation in any hospital deliberation affecting the discharge of medical staff responsibilities.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

3.1.1 Membership on the Medical Staff or the exercise of clinical privileges at Auburn Regional Medical Center shall be granted only to professionally competent physicians and oral surgeons who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

3.2 Qualifications for Membership

3.2.1 Only physicians and oral surgeons licensed to practice and residing in the State of Washington who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and their ability to work with others with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by them in the Hospital will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

3.2.2 No physician or oral surgeon shall be entitled to membership on the Medical Staff or to the exercise of clinical privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice medicine or osteopathy in this or any other state, or that he is a member of any professional organization, or because he is certified by any clinical examining board, or that he had in the past (or presently has) such privileges at another hospital.

3.2.3 Physicians who apply for Medical Staff membership to participate in a hospital-based practice, such as, but not limited to, Radiology, Pathology, Emergency Medicine, and Anesthesiology may be denied membership solely for the reason that the Governing Body and/or Medical Staff do not need or desire further assistance in those departments. The above action will be carried out in the interest of orderly quality patient care.

3.2.4 Acceptance of membership on the Medical Staff constitutes the staff member's agreement that he will strictly abide by all provisions of the Bylaws, Rules and Regulations, Policies and Procedures and by the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, or the Code of Ethics of the American Dental Association, whichever is applicable.

3.2.5 Membership on the Medical Staff requires professional liability insurance as determined by the Medical Executive Committee (MEC).

3.2.6 It is the responsibility of each member of the Medical Staff to provide to the Medical Staff Office current copies of professional license, professional liability insurance coverage, DEA certificate, if applicable, and additional documentation as may be required.

3.3 Conditions and Duration of Appointment

3.3.1 Initial appointment and reappointment to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments, only after there has been a recommendation from the Medical Staff as provided in these Bylaws. In the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation.

3.3.2 Appointments shall be for a period of not more than twenty-four months.

Initial appointments shall be for a provisional period of not less than twelve (12) months and not more than twenty-four (24) months. During the provisional period the physician/oral surgeon's hospital practice is evaluated. The provisional status will be reviewed on the physician/oral surgeon's birth month following a period of at least twelve (12) months and shall constitute the first reappointment to the Medical Staff.

3.3.3 Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

3.3.4 Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his patients, to read and abide by the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures in accordance with the Corporate Bylaws of the Governing Body, and that he agrees to be bound by the terms thereof, to accept committee assignments, to accept assignment on the back up call roster to the Emergency Department, and to accept other special assignments as appropriate.

3.3.5 It is the policy of the Auburn Regional Medical Center Medical Staff to treat all applicants equally, regardless of their race, religion, sex or national origin.

3.4 Appointment/Reappointment and Initial Granting, Renewal/Revision of Clinical Privileges

3.4.1 The mechanisms for appointment/reappointment, initial granting and renewal/revision of clinical privileges are addressed in the Credentials Policy and Procedure Manual which by reference is made part of the bylaws subject to the amendment process outlined in the Credentials Policy and Procedure Manual.

3.4.2 The following procedures are provided as general guidelines for appointment/reappointment to the ARMC Medical Staff.

A. Individuals interested in appointment to the Medical Staff may request an application along with eligibility requirements for membership. Current Members of the Medical Staff will automatically be sent an application for reappointment in a timely fashion.

B. Upon completion and submission of a complete application to the Medical Staff office, verification will be made of the contents and confirmation that the applicant is eligible to have the application processed further as outlined below. If the application shows the applicant is not eligible for membership, he will be notified that no further evaluation or action will occur regarding the application.

C. The Medical Staff Office will prepare the complete and verified file for review and evaluation by the appropriate Department Chair (or designee). The Department Chair will forward a recommendation concerning appointment of the applicant to the Credentials Committee.

D. The Credentials Committee will review the application and forward its recommendation to the Medical Executive Committee (MEC).

E. MEC will review the recommendation and forward its recommendation to the Governing Body regarding membership. MEC may refer an application back to the Credentials Committee if it feels more information or evaluation of the applicant is necessary.

F. The Governing Body will review the recommendation and determine whether to offer the applicant membership and whether any restrictions or conditions should be attached.

G. Applicants may appeal adverse recommendations by MEC and adverse decisions made by the Governing Body in accordance with provisions in these Bylaws, except in cases where the application is deemed incomplete or minimum criteria for processing are not met.

3.4.3 Granting of Clinical Privileges

The following steps describe the process for granting clinical Privileges to qualified applicants. Associated details may be found in the Medical Staff Credentials Policy and Procedure Manual. Practitioners shall be entitled to exercise only those privileges specifically granted to them by the Governing Body. The Medical Staff may recommend clinical privileges for Practitioners who are not members of the Medical Staff but who hold a license to practice independently.

A. Applicants initially applying for Medical Staff membership or for reappointment must complete the appropriate forms to request specific privileges. Applicants ineligible for Medical Staff membership but eligible for privileges will complete the appropriate request forms.

B. Upon completion and submission of the appropriate forms, a designated individual will confirm that the applicant is eligible to have the requests processed further. Privilege requests that do not demonstrate compliance with eligibility requirements will not be processed further.

C. Completed Privilege Request forms will be forwarded to the appropriate Department Chair (or designee) for review and evaluation.

D. The Department Chair will forward a recommendation to the Credentials Committee.

E. The Credentials Committee will review the applicant's requests and the input of the Department Chair and recommend a specific action to the Hospital MEC.

F. MEC will review the privileging requests and recommend specific actions on them to the Governing Body.

G. The Governing Body will review the privileging requests and either reject the requests, modify them, or grant the Privileges being sought.

H. Applicants may appeal adverse recommendations by MEC and adverse decisions made by the Board in accordance with provisions in these Bylaws, except in cases where the application is deemed incomplete, or minimum criteria for processing are not met.

3.4.4 Temporary Clinical Privileges

A. The following documentation is required for temporary privileges:

1. Unrestricted Washington State License
2. Unrestricted Federal DEA as appropriate to specialty
3. State Board of Pharmacy registration as appropriate to specialty
4. Current valid professional liability insurance coverage in a certificate form and in amounts satisfactory to the Hospital
5. Documentation of current standing from primary practicing facility, including privileges requested
6. National Practitioner Data Bank report (processed by the Hospital)
7. A verbal reference which establishes current competency
8. Demonstration of clinical competence.

B. Circumstances

Temporary privileges may be granted to the Practitioner to provide for an important patient care need for a limited time. Temporary privileges may be granted on a case-to-case basis when an important patient care need or service mandates an immediate authorization to practice. Temporary privileges may be granted to the Practitioner upon the recommendation of either the applicable Department Chair or the Chief of Staff or Chief of Staff Elect in the absence of the Chief of Staff provided they meet one of the following circumstances and the minimum criteria as defined below:

C. Pendency of Application for Permanent Medical Staff Membership:

Temporary clinical privileges may be granted pending approval of permanent medical staff membership and privileges, provided the application is complete, and the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed sixty (60) days.

D. Care of Specific Patients:

In special circumstances, upon receipt of a written request for specific temporary privileges, an appropriately licensed Practitioner of documented competence who is not an applicant for membership, may be granted temporary Privileges for the care of one or more specific patients.

E. Locum Tenens:

Upon receipt of a written request for specific temporary privileges, an appropriately licensed Practitioner of documented competence who is

serving as a Locum Tenens for a member of the Medical Staff may, without applying for membership on the Staff, be granted temporary privileges for an initial one hundred and twenty (120) days within a 12-month period. He shall be limited to treatment of the patients of the Practitioner for whom he is serving as a Locum Tenens. He shall not be entitled to admit his own patients to the Hospital unless such privileges are specifically granted. This request must also be accompanied by a written statement from the affected Medical Staff member that he is utilizing the Practitioner as a Locum Tenens.

3.4.5 Conditions

Temporary privileges shall be granted by the Hospital CEO or designee acting on behalf of the Board after approval of the Chief of Staff or a Department Chair. Before temporary privileges are granted, the Practitioner must first acknowledge in writing that he has received and read copies of the Medical Staff Bylaws and all other Medical Staff and Hospital manuals and policies relevant to his performance of temporary Privileges, and that he agrees to be bound by them.

3.4.6 Medical Staff Credentials Policy and Procedure Manual

The Medical Staff delegates to MEC the authority to adopt associated details elaborating on the credentialing and privileging process. Such associated details are found in the Medical Staff Credentials Policy and Procedure Manual which may be annually reviewed and modified as needed.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

4.1 The Medical Staff

4.1.1 The Medical Staff shall be divided into Active, Courtesy, Affiliate and Honorary categories. Appointment to a Staff category will be made on the basis of appropriateness.

4.2 The Active Medical Staff

4.2.1 Eligibility

The Active Medical staff shall consist of physicians and oral surgeons who are able to demonstrate at least twelve (12) direct patient contacts in the facility in a twelve (12) month period. Members of the Active Medical

Staff shall be appointed to a specific department. They will provide for the continuous care of their patients or arrange for admission, care and/or consultation of their patients with another appropriately credentialed member of the medical staff.

4.2.2 Prerogatives

Members of the Active Medical Staff may:

A. Exercise clinical privileges approved by the Board of Governors except as otherwise provided in the Medical Staff governing documents or by specific restriction;

B. Vote on all matters presented at general and special meetings of the Medical Staff, assigned Department and committee meetings of which he is a member.

C. Hold office;

D. Sit on and/or chair committees.

4.2.3 Responsibilities

Members of the Active Medical Staff must:

A. Conform to the provisions of these bylaws and other requirements set forth in the Hospital bylaws and Medical Staff and Department rules, regulations and policies.

B. Actively participate in recognized functions of the Medical Staff including quality improvement and other monitoring activities.

C. Participate in the emergency room and other specialty coverage programs as specified unless exempted by their assigned Department and approved by the Board of Governors.

4.3 The Courtesy Medical Staff

4.3.1 Eligibility

The Courtesy Medical Staff shall consist of physicians and oral surgeons who occasionally practice in the hospital and do not exceed eleven (11) direct patient contacts in a twelve (12) month period. Members of the Courtesy Medical Staff shall be appointed to a specific department. They will provide for the continuous care of their patients or arrange for admission, care and/or consultation of their patients with another appropriately credentialed member of the medical staff.

4.3.2 Prerogatives

Members of the Courtesy Medical Staff may:

A. Exercise clinical privileges approved by the Board of Governors except as otherwise provided in the Medical Staff governing documents or by specific restriction;

B. Attend all Medical Staff, Department and Committee meetings;

C. Vote at Committee meetings of which he is a member but not at Medical Staff or Department meetings.

4.3.3 Responsibilities

Members of the Courtesy Medical Staff must:

A. Conform to the provisions of these bylaws and other requirements set forth in the Hospital bylaws and Medical Staff and Department rules, regulations and policies.

B. Have at least one (1) direct patient contact per year.

C. Members of the Courtesy Medical Staff who do not maintain the minimum required direct patient contacts (1) or who exceed the maximum number of patient contacts (11) shall be so advised. Sixty (60) days from formal notification they shall be automatically assigned to another appropriate category with responsibilities of same.

D. Have both membership and privileges at another area hospital or, if their specialty practice is primarily outpatient, receive recommendation from two (2) members of the active staff at ARMC who can attest to the courtesy staff member's quality of care.

E. Serve on Emergency Department outpatient call rosters as required in the Medical Staff policies.

4.4 Affiliate Staff

4.4.1 Eligibility

The Affiliate Medical Staff shall consist of physicians and oral surgeons who are professionally based within the Hospital's service area (or be granted exception by the Board of Governors) and who, by their association, advance the mission of the hospital. The Affiliate Medical Staff are not granted clinical privileges but refer patients to appropriately credentialed members of the medical staff and hospital services.

4.4.2 Prerogatives

Members of the Affiliate Staff may:

A. Attend meetings of the Medical Staff, Department and Committee meetings;

B. Attend educational programs of the Medical Staff;

C. Visit their patients when hospitalized and review their medical records but may not write orders, make entries in the medical record or actively participate in the management of the patient;

D. Vote at Committee meetings of which he is a member but not at Medical Staff or Department meetings.

4.4.3 Responsibilities
Members of the Affiliate Staff must:

A. Conform to the provisions of these bylaws and other requirements set forth in the Hospital bylaws and Medical Staff and Department rules, regulations and policies.

B. Maintain an active outpatient practice.

C. Provide, if requested at initial or reappointment, a written practice plan regarding their desire to be associated with the hospital.

D. Serve on Emergency Department outpatient call rosters as required in the Medical Staff policies.

4.5 Honorary Medical Staff

4.5.1 The Honorary Medical Staff shall consist of physicians/oral surgeons who are not active in the Hospital and who are honored by emeritus positions. They may be 1) physicians/oral surgeons who have retired from active hospital service, or 2) physicians/oral surgeons of outstanding reputation not necessarily residing in the community. To be appointed to the Honorary Staff, recommendation by the Medical Executive Committee (MEC) or Medical Staff to the Board of Governors is required. Honorary Medical Staff members may not admit patients, shall have no clinical privileges, are not eligible to vote or hold office, and shall have no assigned duties.

ARTICLE V

CORRECTIVE ACTION

5.1 Procedure

5.1.1 Whenever a member of the Medical Staff engages in, makes or exhibits statements, demeanor or professional conduct, either within or outside of the Hospital, which is reasonably likely to be detrimental to patient safety

or to the delivery of quality patient care, disruptive to Hospital operations or an impairment of the community's confidence in the Hospital, a request for review and corrective action against the physician/oral surgeon may be initiated by any member of the Medical Staff, Administration or Governing Body. Such request shall be in writing to the Medical Executive Committee (MEC) and shall be supported by reference to specific activities or conduct which constitutes the grounds for the request.

5.1.2 MEC shall forward such request to the Chairman of the Medical Staff Quality Improvement Committee (MSQIC). Upon receipt of such request, the Chairman of MSQIC shall promptly initiate an investigation of the matter.

5.1.3 MSQIC shall promptly arrange a meeting with the physician/oral surgeon under investigation who shall have an opportunity to discuss the situation with the committee. He shall be informed of the general nature of the basis for the investigation 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. The investigation shall proceed in a prompt manner and a written report of the investigation findings will promptly be submitted to MEC, including recommended actions, if any, and a record of any interviews held with the subject physician/oral surgeon.

5.1.4 Within thirty (30) calendar days following receipt of a report from MSQIC in regard to its investigation of a complaint, MEC shall meet to consider the report. If corrective action has been recommended, the affected physician/oral surgeon shall be permitted to make an appearance before MEC prior to its taking action. This appearance 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 such appearance shall be made by MEC.

5.1.5 The action of MEC may be to reject or modify the MSQIC recommendation; to issue a warning, a letter of admonition, a letter of reprimand; to impose terms of probation; to require consultation; to recommend reduction, suspension or revocation of clinical privileges; to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; to recommend that the physician/oral surgeon's Medical Staff membership be suspended or revoked; or act in any other way it deems prudent.

5.1.6 Any recommendation by MEC for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff,

shall entitle the affected physician/oral surgeon to the procedural rights provided in Article VI of these Bylaws.

5.2 Summary Suspension

5.2.1 The Managing Director, Chief of Staff, or Chairman of a Department (on matters within that department), shall have the authority to summarily suspend all or any portion of the clinical privileges of a physician/oral surgeon whenever such action must be taken immediately in the best interest of patient care in the Hospital. Such summary suspension shall become effective immediately upon imposition.

5.2.2 A physician/oral surgeon whose clinical privileges are summarily suspended will be afforded an interview with MEC if so requested. The interview shall not constitute a hearing, shall be informal in nature, and shall not be conducted according to the procedural rules provided for in Article VI of these Bylaws. Request to meet with MEC must be made within five (5) days of receipt of notification of the summary suspension. Request must be made in writing and delivered to the Chief of Staff or designee within the designated time frame. The meeting with MEC will be scheduled promptly after imposition of the suspension.

5.2.3 MEC will review and act on the summary suspension, in any case, within 14 days of its imposition. If MEC does not recommend immediate reversal of the summary suspension, the affected physician/oral surgeon shall, in accordance with Article VI, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or modified by MEC shall remain in effect pending a final decision thereon by the Governing Body.

5.2.4 Immediately upon the imposition of a summary suspension, the Chief of Staff, or responsible Department Chairman, or Managing Director, shall have the authority to provide for alternative medical coverage for the patient(s) of the suspended physician/oral surgeon still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative physician/oral surgeon.

5.3 Automatic Suspension and Procedures for Dismissal

5.3.1 Automatic suspensions and limitations on Medical Staff membership, clinical privileges and voluntary resignations/relinquishments of Medical Staff membership and clinical privileges may occur for administrative reasons relating to failure to comply with eligibility requirements of membership or with additional requirements for Medical Staff membership or clinical privileges found in the Medical Staff Bylaws, Rules, Regulations,

and Medical Staff Credentials Policy and Procedure Manual. An administrative suspension of clinical privileges may be made under the Chief of Staff representing MEC as described in this section. Unless otherwise stated, such administrative suspension shall be effective immediately upon imposition and MEC shall deliver written notice to the affected member. These actions are generally not considered professional review actions, they are not based on determinations of competence or unprofessional conduct, and they do not entitle the affected physicians/oral surgeon to the hearing or appeal procedures provided under Article VI of these bylaws. These actions include:

5.3.2 Action by the State Board of Medical Examiners or the State Medical Disciplinary Board revoking or suspending a physician/oral surgeon's license, shall automatically suspend all of his Hospital privileges and revoke his Medical Staff membership. Probation action by either of the above Boards may be grounds for suspension of a physician/oral surgeon's Hospital privileges. If a member's license to practice in Washington State lapses, the member's clinical privileges shall be suspended until the deficiency is corrected. If, within 90 days following the lapse, the member does not demonstrate that the member's license to practice in Washington State has been renewed, the member's Medical Staff membership and clinical privileges shall be automatically revoked.

5.3.3 Any member of the Medical Staff who is convicted of a felony shall be immediately suspended from all staff privileges by the Managing Director, acting as the officer of the Governing Body. MEC shall review this action at its next regular meeting, or at a special meeting called for this purpose. However, nothing in this section shall prevent the Governing Body from proceeding under its own Bylaws with dismissal of a member of the Medical Staff, regardless of whether or not MEC has made recommendation for dismissal.

5.3.4 Action by the Drug Enforcement Administration (DEA) or Washington Pharmacy Board revoking, relinquishing, or suspending a license/number to prescribe drugs covered by such number/licenses within the Hospital.

5.3.5 Any member of the Medical Staff shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the governing body and these Bylaws. If within 90 days following the deficiency, the member does not provide evidence of required professional liability insurance, the member's Medical Staff membership and clinical privileges may be revoked.

5.3.6 If a member of the Medical Staff appears on the list of "Excluded Individuals/Entities" maintained by the Health and Human Services Office of Inspector General, or is excluded from any Federal or State insurance

programs, the affected physician/oral surgeon shall be considered to have automatically resigned from Medical Staff membership and/or clinical privileges. Similarly, any physician/oral surgeon found to have violated the Federal False Claims Act or been convicted of insurance fraud shall be considered to have automatically relinquished Medical Staff membership and/or clinical privileges.

5.3.7 If a member fails to complete and sign medical records in accordance with Hospital policy, the member's clinical privileges may be suspended until the deficiency is corrected.

5.3.8 A staff member who has been informed that his presence has been requested to discuss case management at any committee, departmental, or Medical Staff meeting, must be in attendance or have an acceptable excuse for his absence. Members of the Medical Staff who willfully ignore this regulation will lose their membership. Reinstatement of a staff member whose membership has been revoked because of absence from such meetings, shall be made only upon application which shall be processed in the same manner as for an original applicant.

5.3.9 It shall be the duty of the Chief of Staff to enforce all suspensions.

ARTICLE VI

HEARING AND APPELLATE REVIEW PROCEDURE

6.1 Right to Hearing and to Appellate Review

6.1.1 When any physician/oral surgeon receives notice of a recommendation of the Medical Executive Committee (MEC) that will adversely affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, based on a determination of professional competency or professional conduct, he shall be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of MEC following such a hearing is still adverse to the affected physician/oral surgeon, he shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter. The following recommendations, based on a determination of professional competency or professional conduct, shall constitute grounds for a hearing:

A. Denial of initial appointment or reappointment to the Medical Staff;

B. Revocation of appointment to the Medical Staff;

C. Denial or revocation of some or all requested clinical privileges;

D. Suspension or restriction of some or all clinical privileges for more than fourteen (14) days.

6.1.2 The following will NOT constitute grounds for a hearing (this list is not meant to be exhaustive).

A. Having a letter of guidance, warning, or reprimand issued to the physician/oral surgeon or placed in the credentials or performance file of the Physician;

B. Automatic suspension or relinquishment of clinical privileges or Medical Staff membership as described in Article V, Section 5.3 above;

C. Imposition of a summary suspension that does not last for more than fourteen (14) days;

D. Denial of a request for a leave of absence;

E. Determination that an application for appointment or reappointment is untimely or incomplete for failure to submit all requested information;

F. A decision not to process an application under the available procedures for expedited review;

G. Assignment to a particular Medical Staff Department or category;

H. Imposition of a proctoring or monitoring requirement where such does not include a restriction on clinical privileges;

I. Failure to process a request for a clinical privilege when the applicant/Medical Staff member does not meet the eligibility requirements to hold that clinical privilege;

J. Requirement to appear for a special meeting under the provision of the Medical Staff Bylaws;

K. Termination or limitation of temporary clinical privileges unless for reasons involving professional competency or professional conduct;

L. Determination that an applicant for Medical Staff membership does not meet the requisite qualifications or criteria for Medical Staff membership

M. Ineligibility to request Medical Staff membership or clinical privileges, or to continue the exercise of clinical privileges, because a relevant specialty is closed under a Medical Staff development plan adopted by the Governing Body.

N. Ineligibility to request Medical Staff membership or clinical privileges, or to continue the exercise of clinical privileges, because a relevant

specialty is covered under an exclusive provider agreement approved by the Governing Body;

O. Termination of any contract with or employment by the Hospital;

P. Any recommendation voluntarily accepted by the Medical Staff member as a result of collegial peer review;

Q. Imposition, removal or limitation of emergency department call obligations;

R. Any requirement by MEC or the Governing Body to complete an educational assessment;

S. Any requirement by MEC or Governing Body to undergo a mental, behavioral, or physical evaluation to determine fitness for practice if such evaluation is a qualification for Medical Staff membership and/or clinical privileges;

T. Appointment or reappointment for a duration of less than twenty-four (24) months;

U. Refusal of the Governing Body to reinstate Medical Staff membership or clinical privileges following a leave of absence;

V. Actions taken by the affected physician's licensing agency or any other governmental agency or regulatory body.

6.1.3 When any physician/oral surgeon receives notice of a decision by the Governing Body that will affect his appointment to or status as a member of the Medical Staff, or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by MEC with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by a committee appointed by the Governing Body, and if such hearing does not result in a favorable recommendation, to an appellate review by the Governing Body before the Governing Body makes a final decision of the matter.

6.1.4 All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article to assure that the affected physician/oral surgeon is accorded all rights to which he is entitled.

6.1.5 A verbatim transcript of the hearings will be made.

6.2 Request for Hearing

6.2.1 The Managing Director shall be responsible for giving prompt written notice to any affected physician/oral surgeon who is entitled to a hearing,

or to an appellate review, by certified mail, return receipt requested. The notice shall:

A. Advise the applicant of his right to a hearing or an appellate review pursuant to Article VI of these Bylaws;

B. State in concise language the acts or omissions with which the physician/oral surgeon is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision;

C. Specify that he shall have thirty (30) calendar days following the date of receipt of such notice within which to request a hearing or an appellate review;

D. State that failure to request a hearing or an appellate review within the specified time period constitutes a waiver of his right to same.

6.2.2 The failure of a physician/oral surgeon to request a hearing within thirty (30) calendar days to which he is entitled by these Bylaws, and in the manner herein provided, shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter. The failure of a physician/oral surgeon to request an appellate review to which he is entitled by these Bylaws within the time and in the manner herein provided, shall be deemed a waiver of his right to such appellate review on the matter.

6.2.3 When the waived hearing or appellate review relates to an adverse recommendation of MEC, or of a hearing committee appointed by the Governing Body, the same shall thereupon become and remain effective against the physician/oral surgeon pending the Governing Body decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Body, the same thereupon becomes and remains effective against the physician/oral surgeon in the same manner as a final decision of the Governing Body. In either of such events, the Managing Director shall promptly notify the affected physician/oral surgeon of his status by certified mail, return receipt requested.

6.3 Notice of Hearing

6.3.1 Within thirty (30) days after receipt of a request for a hearing from a physician/oral surgeon entitled to same, MEC or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing

and shall, through the Managing Director, notify the physician/oral surgeon of the time, place, and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) calendar days, nor more than sixty (60) calendar days, from the date of receipt of the request for hearing, provided however, that a hearing for a physician/oral surgeon who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than thirty (30) calendar days from the date of receipt of such physician/oral surgeon's request for hearing. Together with the notice of the hearing, the affected physician/oral surgeon shall be provided a written statement outlining the acts or omissions which support the decision to impose or recommend an adverse action against the physician/oral surgeon. A list identifying relevant medical records, and other data which form the basis for the action will be made available.

6.4 Composition of Hearing Committee

6.4.1 When a hearing relates to an adverse recommendation of MEC, such hearing shall be conducted by an ad hoc Hearing Committee of not less than three (3) members of the Medical Staff in consultation with MEC, and one (1) of the members so appointed shall be designated as Chairman. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee unless it is otherwise impossible to select a representative group.

6.4.2 When a hearing relates to an adverse decision of the Governing Body that is contrary to the recommendation of MEC, the Governing Body shall appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this committee as Chairman. At least one representative from the Medical Staff shall be included on this committee when feasible.

6.5 Conduct of Hearing

6.5.1 There shall be at least two-thirds of the members of the Hearing Committee present when the hearing takes place and no member may vote by proxy.

6.5.2 An accurate record of the hearing must be kept.

6.5.3 The personal presence of the physician/oral surgeon for whom the hearing has been scheduled shall be required. A physician/oral surgeon who fails without good cause to appear at such hearing shall be deemed to have waived his rights in the same manner as stated in Section 6.2 of this

Article and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect.

6.5.4 Postponement of hearings beyond the time as set forth in these Bylaws shall be made only with the approval of the ad hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and at the sole discretion of the Hearing Committee.

6.5.5 The affected physician/oral surgeon shall be entitled to be accompanied by and/or represented at the Hearing by a member of the Medical Staff in good standing, or by a member of his local professional society, and to utilize legal counsel in preparation for the hearing. The Hearing Committee has the discretion to limit the role or legal counsel for either side during the hearing; however, such counsel may be present at the hearing to advise his client, and participate in resolving procedural matters.

6.5.6 Either a hearing officer, if one is appointed, or the Chairman of the Hearing Committee, or his designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

6.5.7 The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The physician/oral surgeon for whom the hearing is being held shall, prior to or during the meeting, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record. The physician/oral surgeon for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The Committee shall also be entitled to consider any pertinent material contained in connection with applications for appointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

6.5.8 MEC, when its action has prompted the hearing, shall appoint one of its members, or some other Medical Staff member, to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision, and to examine witnesses. It shall be the obligation of such representative to

present appropriate evidence in support of the adverse recommendation or decision, but the affected physician/oral surgeon shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by showing by a preponderance of the evidence that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

6.5.9 The affected physician/oral surgeon shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the physician/oral surgeon does not testify in his own behalf, he may be called and examined as if under cross-examination. The Hearing Committee may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in the state where the hearing is held.

6.5.10 The hearings provided for in these Bylaws are for the purpose of resolving, on an inter-professional basis, matters bearing on professional competency and conduct. The Hearing Committee has the discretion to limit the role of legal counsel for either side during the hearing. However, this limitation does not deprive the Physician or Hospital of the right to utilize legal counsel in preparation for the hearing and such counsel may be present at the hearing to advise his client and participate in resolving procedural matters.

6.5.11 The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the physician/oral surgeon for whom the hearing was convened.

6.5.12 Within ten (10) calendar days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to MEC or to the Governing Body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of MEC or decision of the Governing Body.

6.5.13 Within thirty (30) calendar days, the affected physician/oral surgeon may request appellate review from the Governing Body. The procedure will be carried out according to provisions of this Article, and according to Governing Body regulations.

6.6 Limit of One Hearing and One Appeal

6.6.1 No applicant or member of the Medical Staff shall be entitled as a matter of right to more than one evidentiary hearing in total before a Hearing Committee based on a single action of MEC or the Governing Body. No applicant or member of this Medical Staff shall be entitled as a matter of right to more than one appellate review in total before the Governing Body on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by MEC, the Governing Body, or a combination of actions by such bodies.

6.7 Exhaustion of Administrative Remedies

6.7.1 By applying for membership on the Medical Staff or for clinical privileges, each applicant agrees that, in the event of any adverse action or decision with respect to the Medical Staff membership and/or clinical privileges, the applicant or Medical Staff member shall exhaust the administrative remedies afforded by these Medical Staff Bylaws before resorting to formal legal action.

ARTICLE VII

OFFICERS OF THE MEDICAL STAFF

7.1 Composition and Function

7.1.1 Officers of the Medical Staff shall be

A. Chief of Staff
B. Chief of Staff-elect
C. Immediate past Chief of Staff
D. Secretary/Treasurer

7.1.2 Qualifications of Officers

The officers must be members of the Active Staff in good standing at the time of nomination and election, and must remain in good standing during their term in office. Failure to maintain such status will immediately terminate the term in office.

7.1.3 Election and Termination of Officers

A. The Nominating Committee shall select two (2) candidates for each of the two offices of Chief of Staff-elect and Secretary/Treasurer,

and shall submit their selection of candidates to the Medical Executive Committee (MEC) for approval three (3) months before the biennial meeting of the Medical Staff. The Medical Staff shall receive written notification of the nominees and may forward nominations for additional candidates to the Secretary-Treasurer at least two (2) months before the biennial meeting. Nominees who agree to run for office shall be named on the ballot.

B. Election of officers shall be by mail ballot during the month of October.

C. Validation of the election shall require ballots returned from two-thirds (2/3) of the Active Staff membership. The candidate receiving the largest number of votes shall be elected. A tie vote from the balloting shall be resolved by presenting the names of the members tied at the biennial staff meeting. The candidate receiving the largest number of votes shall be elected.

D. If no validation is reached through the mail ballot, the election shall be held at the biennial staff meeting.

E. Elected officials shall hold office for a period of two years. The Chief of Staff shall not hold office for two consecutive terms. The final list of officers shall be announced at the biennial staff meeting and submitted to the Governing Body.

F. Newly elected officers will commence functions effective January 1 following the biennial staff meeting, assuming responsibility for any carry-over business, and assuming authority for follow-through actions of the previous officers, as necessary.

G. If an officer, with the exception of the Chief of Staff, is unable to complete his term in office, an election will be held at the next regular or special meeting of the Medical Staff. His successor will serve the unexpired term.

H. An elected officer may be replaced by a two-thirds (2/3) majority vote of the Active Staff for valid cause including, but not limited to, failure or inability to perform his duties, gross neglect in office, or serious acts of moral turpitude. Call for the vote shall be approved by either MEC or Board of Governors who shall recommend vote by mail ballot or at the next regular or special meeting of the Medical Staff. No removal shall be effective unless it is ratified by MEC and the Board of Governors.

7.1.4 Duties of Officers

A. Chief of Staff

1. To serve as the chief administrative officer of the Medical Staff and act in coordination and cooperation with the Managing Director in all matters of mutual concern within the Hospital.

2. To preside at all general meetings of the Medical Staff and be responsible for the agenda of those meetings.

3. To serve on MEC and act as its presiding officer.

4. To serve as an ex-officio member of all other Medical Staff Committees.

5. To receive and interpret the policies of the Governing Body to the Medical Staff.

6. To carry out the enforcement of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures and to implement necessary sanctions against physicians/oral surgeons in all instances where corrective action has been properly recommended.

7. To be responsible for the functioning of the clinical organization of the Hospital, and to keep, or cause to be kept, supervision over the clinical work done in the Hospital.

8. To appoint committee members to all committees as provided in these Bylaws and Policies and Procedures.

9. To report to the Governing Body, as requested, on the performance and maintenance of the quality of medical care.

10. To be the spokesman for the Medical Staff in its external professional and public relations.

11. To serve as an ex-officio member of the Governing Body; to function as a liaison between the Governing Body and the Medical Staff in accordance with the Bylaws of the Governing Body.

B. Chief of Staff-elect

1. To assume, in the absence of the Chief of Staff, the authority of and to carry out the duties of the Chief of Staff.

2. To serve as a member of MEC.

3. To automatically succeed the Chief of Staff if the latter should fail to complete his term of office for any reason.

4. To perform specific administrative duties relating to the Medical Staff as may be assigned to him by the Chief of Staff.

C. Immediate Past Chief of Staff

1. To serve as a member of MEC.

2. To perform such duties as may be assigned to him by the Chief of Staff.

D. Secretary/Treasurer

1. To serve as a member of MEC.

2. To call meetings by order of the Chief of Staff.

3. To submit reports at appropriate times on the status of the Medical Staff funds.

4. To attend to all correspondence and perform such other duties as ordinarily pertain to this office.

ARTICLE VIII

DEPARTMENTS OF THE MEDICAL STAFF

8.1 Definition of Departments

8.1.1 The Medical Staff shall be organized into Departments representing Anesthesiology, Emergency Services, Family Practice, Medicine, Obstetrics and Gynecology, Pediatrics, Radiology and Surgery. Other departments may be organized as the need arises.

8.1.2 Each member shall be assigned to one (1) department.

8.1.3 Each Medical Staff department shall meet on a regular basis to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care rendered to patients in the Hospital.

8.2 Organization of Departments

8.2.1 Each Department shall elect a Chairman who shall be responsible for the functioning of the Department, and a Vice-Chairman who will assume this responsibility in the absence of the Chairman.

8.3 Qualifications, Selection, and Tenure of the Chairman and Vice-Chairman

8.3.1 Each Chairman and Vice-Chairman must be a member of the Active Staff in good standing. Each Chairman shall be certified by an appropriate specialty board or comparable competency shall be affirmatively established through the credentialing process.

8.3.2 Each Chairman and Vice-Chairman shall be elected by the voting members of his Department for a two (2) year term, subject to approval of the Medical Executive Committee (MEC) and the Governing Body. The election shall take place at the departmental meeting immediately preceding the biennial Medical Staff meeting. The term shall coincide with the term of the Medical Staff officers.

8.3.3 Removal of Department officers for valid cause includes, but is not limited to, failure or inability to perform their duties, gross neglect in office, or serious acts of moral turpitude. Removal may be initiated by a petition to MEC by twenty percent of the Active Staff members of that Department. Within ten (10) calendar days after receipt of a petition for removal, MEC will canvas all Active Staff members of that Department. A two-thirds (2/3) vote of the members shall be required for removal, but no removal shall be effective unless it is ratified by MEC and the Governing Body.

8.4 Functions of Departments

8.4.1 Each Department shall establish its own criteria with policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges and for the holding of office in the Department, and shall appoint committees to function as needed. MEC shall resolve any conflict in policies or functions between Departments.

8.4.2 Each Department shall be responsible for conducting a review of the clinical work performed in that Department in concert with the Medical Staff Quality Improvement Committee (MSQIC). It is the Department's

duty to review and evaluate the quality of patient care. This review may include, but shall not be limited to case review as appropriate and determined by the Department. This may include records of members of other Departments whose practice overlaps in similar clinical areas.

8.4.3 The minutes of the Department/Committee meetings will be reviewed and acted upon by MEC.

8.5 Functions of the Department Chairman

8.5.1 Shall be responsible for all clinical and administrative (unless otherwise provided for by the hospital) activities within the Department.

8.5.2 Shall serve as a member of MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions concerning his own Department regarding quality of patient care.

8.5.3 Appoint Department Committees to conduct the functions required of each Department in these Bylaws.

8.5.4 Shall be responsible for the implementation within his Department of actions taken by MEC, and be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures within his Department, in accordance with the Hospital Bylaws.

8.5.5 Shall be responsible for the review of clinical cases, education, teaching and research programs in the Department as part of the ongoing surveillance of the professional performance of all individuals who have clinical privileges in the Department.

8.5.6 Shall recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department.

8.5.7 Shall recommend clinical privileges for each member of the Department.

8.5.8 Shall see that the quality and appropriateness of patient care rendered within that Department is monitored and evaluated.

8.5.9 Shall assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization.

8.5.10 Shall participate in administrative functions of the Department through cooperation with the Nursing Service and Hospital Administration in matters affecting patient care including:

A. The integration of the department or service into the primary functions of the organization.

B. The coordination and integration of interdepartmental and intradepartmental services.

C. The development and implementation of policies and procedures that guide and support the provision of services.

D. The recommendations for a sufficient number of qualified and competent persons to provide care or service.

E. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services.

F. The continuous assessment and improvement of the quality of care and services provided.

G. The maintenance of quality control programs, as appropriate.

H. The orientation and continuing education of all persons in the department or service.

I. Recommendations for space and other resources needed by the department or service.

8.6 Attendance Requirements

8.6.1 Active Medical Staff members are expected to attend the regularly scheduled departmental meetings in the Department of which he is a member unless excused by the Chairman of the Department for just cause.

ARTICLE IX

COMMITTEES (NON-DEPARTMENTAL)

9.1 Definition

9.1.1 Non-departmental committees shall be both standing and special. Non-Medical Staff members of these committees serve in an advisory capacity, without vote, except where specifically permitted.

9.1.2 Other than the Medical Executive Committee (MEC), committees and their chairmen shall be appointed by the Chief of Staff, with the approval of MEC. Committee membership shall be announced as soon as practical after the biennial staff meeting and will become functional the following January 1.

9.1.3 All committees shall report directly to MEC. See Article VIII, Sections 8.4, 8.5 and 8.6, for discussion of departmental committees. Business may be transacted when a quorum is present. Any conflict between committees, or committees and departments, will be referred to MEC for resolution.

9.2 Standing Committees

9.2.1 Medical Executive Committee

A. Composition: Officers of the Medical Staff and the Chairmen of the Departments as described in Article VIII, Section 8.5.2. A majority of voting Medical Executive Committee members are fully licensed physician/oral surgeon members of the Medical Staff actively practicing in the Hospital. The Chief of Staff shall be the Chairman of MEC and shall preside over its deliberations. The Managing Director shall be an ex-officio member without vote, and he shall sit with MEC in an advisory capacity. The Risk Manager shall be an ex-officio member. Representatives from hospital departments will be invited as felt necessary by this committee. No medical staff member actively practicing in the hospital is ineligible for membership on MEC solely because of his or her professional discipline or specialty.

B. Meetings: At least once a month and a permanent record of its proceedings and actions shall be maintained.

C. Duties and Responsibilities:

1. To represent and act on behalf of the Medical Staff as set forth in these Bylaws.

2. To coordinate the activities and general policies of the various departments.

3. To receive and act upon committee and departmental reports and minutes.

4. To implement policies of the Medical Staff not otherwise delegated to the Departments.

5. To provide liaison between the Medical Staff, Managing Director, and Governing Body and to make recommendations directly to the governing body regarding:

    a. Structure of the Medical Staff.

    b. Mechanism used to review credentials and to delineate individual clinical privileges.

    c. Participation of the Medical Staff in organizational performance improvement activities.

    d. Mechanism by which Medical Staff membership may be terminated.

    e. Mechanism for fair-hearing procedures.

6. To participate in maintaining the accreditation status of the Hospital.

7. To fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital.

8. To review the credentials of all applicants and to make recommendations to the Governing Body for staff membership, assignments to Departments, and delineation of clinical privileges.

9. To periodically review all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges, and as a result of such reviews, to make recommendations for reappointment and renewal or changes in clinical privileges.

10. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance of all members of the Medical Staff, including corrective actions when warranted.

11. Disaster Planning: To participate in the development and maintenance of methods for the protection and care of Hospital patients and others at the time of internal and external disaster.

12. To report at each general Medical Staff meeting.

13. To function as part of the hospital's Peer Review and Performance Improvement Program. A liaison relationship is established with the designated peer review committee. Quality Improvement Team data is shared with MEC and any action involving the physician/oral surgeon peer review process is referred directly to MEC for action/implementation and to the Governing Body for information and/or action.

9.2.2 Credentials Committee

A. Composition: Chairman and at least four (4) other members of the Active Medical Staff, so selected as to ensure adequate representations of the whole Medical Staff. Representatives from hospital departments will be invited as felt necessary by this committee.

B. Meetings: Monthly with a minimum of 10 meetings per year and a permanent record of its proceedings and actions shall be maintained.

C. Duties and Responsibilities:

1. To review the credentials of all initial applicants and to make recommendations in conformance with the Medical Staff Bylaws.

2. To review the qualifications and performance of all Medical Staff, Medical Associates and Allied Health Members at reappointment.

3. Minutes of the Credentials Committee shall be forwarded to MEC and shall include recommendations relating to appointment/reappointment, Staff category, department and clinical privileges.

9.2.3 Medical Staff Quality Improvement Committee (MSQIC)

A. Composition: Chairman and at least four (4) other members of the Active Medical Staff, so selected as to ensure adequate representations of the whole staff. Representatives from hospital departments will be invited as felt necessary by this committee. The chair of the MSQIC will be appointed by the Chief of Staff, and will have voting privileges on MEC.

B. Meetings: Monthly with a minimum of 10 meetings per year and a permanent record of its proceedings and actions shall be maintained.

C. Duties and Responsibilities:

1. To conduct quality of care investigations and focused peer review. When required, report its findings, conclusions, and recommendations to MEC.

2. To periodically review information available regarding the performance and competency of Practitioners, and to conduct, as appropriate, focused professional practice evaluations.

3. To review clinical and safety outcomes for major illnesses and procedures against national benchmarks.

4. To make recommendations to the Hospital's Continuing Medical Education and Risk Management Departments regarding priorities for educational activities and risk management activities;

5. To make available to the Credentials Committee its files relating to performance and competence reviews, including, but not limited to: documentation of its findings, recommendations, and conclusions;

6. MSQIC shall maintain written reports and minutes of its activities, which shall be forwarded to MEC and shall include recommendations relating to appointment/reappointment, Staff category, department and clinical privileges.

9.3 Special Committees

9.3.1 Special Committees may be appointed from time to time by the Chief of Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report as instructed. They shall not have power of action unless such is specifically granted in the appointment.

9.3.2 In addition to these committees, ad hoc committees for the purpose of review and evaluation of the quality of patient care may be appointed from time to time by resolution of the Medical Staff Committee or Department at a special or regular meeting called for that purpose; the Chairman and members are to be designated by the Chief of Staff. The action taken shall be set forth in written minutes of the Medical Staff Committee meeting, and shall be subject to confirmation by the Governing Body.

9.4 Attendance Requirements

9.4.1 Members of the Medical Staff committees are expected to attend scheduled meetings unless excused for just cause by the committee chairman.

ARTICLE X

MEDICAL STAFF MEETINGS

10.1 Biennial Meeting

10.1.1 Alternate December meetings shall serve as the Biennial meeting. If appropriate, the election of Officers and Department Chairmen will be announced. Floor balloting may be conducted to validate any election process as described in these Bylaws.

10.2 Medical Staff Meetings

10.2.1 Meetings of the Medical Staff will be held twice yearly, one of which will be held in December; both are recognized regular meetings for attendance purposes, and will cover matters of organization and administration of Medical Staff Affairs.

10.2.2 The agenda will include a report from the Medical Executive Committee (MEC), appropriate reports from Committee and Department Chairmen, and may include a program of scientific interest. The business of the Medical Staff will be conducted by members of the Medical Staff.

10.2.3 The date, time, and place of the meetings will be agreed upon by MEC, and adequate written notice given.

10.3 Special Meetings

10.3.1 Special meetings may be called at any time by the Chief of Staff, or by request of the Governing Body, Medical Executive Committee, or twenty percent of the members of the Active Staff.

10.3.2 Written notice stating the subject, time, and place of any special meeting shall be delivered in the Hospital mailbox of each member of the Active Staff, not less than ten (10) or more than thirty (30) calendar days before the date of such meetings, at the direction of the Chief of Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.4 Transacting Business

10.4.1 At any meeting, a quorum is required to transact business, except as otherwise provided in these Bylaws, Rules and Regulations.

10.4.2 Robert's Rules of Order shall be the parliamentary authority.

10.5 Attendance Requirements

10.5.1 Members of the Active Medical Staff are expected to attend medical staff meetings.

10.5.2 Members of the Honorary and Courtesy shall not be required to attend meetings, but it is desirable that they attend and participate in those meetings of special interest to them.

ARTICLE XI

IMMUNITY FROM LIABILITY

11.1 Definition

The following shall be express conditions to any Practitioner's application for, or exercise of, clinical privileges at this Hospital.

11.1.1 That any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining

quality patient care in this or any other healthcare facility, shall be privileged to the fullest extent permitted by law.

11.1.2 That such privilege shall extend to members of the Hospital's Medical Staff and of its Governing Body, its other practitioners, its Managing Director and his representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

11.1.3 That there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

11.1.4 That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other healthcare institution's activities related to, but not limited to:

A. Applications for appointment or clinical privileges.

B. Periodic reappraisal for reappointment or clinical privileges.

C. Corrective action, including summary suspension.

D. Hearings and appellate reviews.

E. Medical care evaluations.

F. Utilization reviews.

G. Other Hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

11.1.5 That the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a practitioner's professional qualifications, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

11.1.6 That in furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in Section 11.1.2, subject to such requirements, including those of good

faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

11.1.7 That the consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of this hospital's practitioners, other appropriate Hospital officials and personnel, and third Parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE XII

STAFF RULES AND REGULATIONS/SUPPLEMENTAL MANUALS/ POLICIES & PROCEDURES

12.1 The Medical Staff shall adopt such Rules and Regulations, supplemental manuals, and policies and procedures as may be necessary to implement more specifically the general principles found within these Bylaws. These documents shall relate to the proper conduct of Medical Staff organizational activities and to the level of practice that is to be required and expected of staff members in the Hospital. These documents may be adopted, amended or repealed by action of the Medical Executive Committee (MEC) and such action will become effective upon approval of the Board of Governors.

12.2 MEC is delegated authority to develop such rules, regulations, policies or procedures as may be necessary to more specifically implement the general principles found within these Bylaws and to regulate the proper conduct and clinical practices of the Medical Staff, subject to the procedures below. The Medical Staff Credentials Policy and Procedure Manual shall be classified as policies and procedures subject to MEC's delegated authority. The Medical Staff may also propose rules, regulations, and policies to MEC for consideration or may propose rules, regulations, and policies directly to the Governing Body, in accordance with the procedure set out in Paragraph 12.4 below.

12.3 Any rule, regulation, policy or procedure adopted by MEC and approved by the Governing Body shall be promptly communicated to the Medical Staff.

12.4 Rules, regulations, policies and procedures may also be proposed by a petition signed by a minimum of twenty percent (20%) of the voting members of the Active Staff. If a properly supported petition seeks to propose rules, regulations, policies or procedures for a Medical Staff vote in writing, then it shall first be submitted to MEC for review and comment before such rule, regulation, policy or procedure is voted on by the Active Staff. Any rule, regulation, policy or procedure approved by a simple majority of the voting members of the Active Staff shall be presented to the Governing Body for consideration along with any comments from MEC.

12.5 All proposed Medical Staff rules, regulations, policies or procedures shall become effective only after approval by the Governing Body.

ARTICLE XIII

AMENDMENTS

13.1 Amendment Procedures shall be as follows:

13.1.1 Amendment to these Bylaws may be initiated at any time by the Governing Body, the Chief of Staff, the Medical Executive Committee (MEC), the Bylaws Committee, or by request of twenty percent of the Active Staff members. The proposed amendment must be submitted in writing to the Chief of Staff, who may refer it to the Bylaws Committee, which will report its recommendations to MEC. The Chief of Staff will place this on the agenda of the next regularly scheduled MEC meeting.

13.1.2 After consideration, MEC will forward recommendations to the Active Medical Staff, allowing opportunity for comment. Comments will be reviewed/discussed by MEC after which the final proposed amendment(s) will be distributed by mail or electronic ballot according to such procedures as are approved by MEC. A proposed amendment must be voted upon by a simple majority of the Active Medical Staff. A simple majority of the vote will carry.

13.1.3 Bylaws amendments approved by MEC and the Medical Staff shall be forwarded to the Governing Body for consideration, and the Governing Body may approve, disapprove, or approve with modifications, any proposed Bylaws amendment. If the Governing Body modifies any Bylaws amendments after it has been approved by MEC and the Medical Staff, then such amendments, as modified, shall be returned to MEC, which may accept or reject the modifications adopted by the Governing Body. If MEC accepts the modifications, the amendment shall be submitted to the voting Medical Staff for approval or disapproval in accordance with this Article. MEC or the Governing Body may require that any disputes regarding proposed Bylaws amendments be referred to a Joint Conference Committee, as set out below in Article XIV, for discussion and further recommendation to MEC and the Governing Body.

13.1.4 Amendments shall become effective when approved by the Governing Body of the Hospital.

13.1.5 Neither the Medical Staff nor the Board of Governors may unilaterally revise or amend these bylaws, rules and regulations.

ARTICLE XIV

CONFLICT RESOLUTION

14.1 The Conflict Resolution Process shall be as follows:

14.1.1 In the event of a conflict between the voting members of the Active Staff and the Medical Executive Committee (MEC) regarding the adoption of any Bylaw, rule, regulation, policy or procedure, or any amendment thereto, or with regard to any other matter, then upon a petition signed by twenty percent (20%) of the voting members of the Active Staff, the matter shall be submitted to the conflict resolution process identified below.

14.1.2 A Conflict Resolution Committee shall be formed consisting of up to three (3) representatives of the Active Staff designated by the Active Staff members submitting the petition and an equal number of representatives of MEC appointed by the Chief of Staff. The Hospital CEO or designee shall be an ex-officio non-voting member of any Conflict Resolution Committee.

14.1.3 The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting patient safety and quality.

14.1.4 Any recommendation which is approved by a majority of the Active Staff representatives and a majority of MEC representatives on the Conflict Resolution Committee shall be submitted to the Governing Body for consideration and final approval. If the Conflict Resolution Committee cannot reach agreement by a majority of the Active Staff representatives and a majority of MEC representatives, then the members of the Conflict Resolution Committee shall individually or collectively report to the Governing Body regarding the unresolved differences. The Governing Body will consider the unresolved issues prior to making its final decisions regarding the matter in dispute.

14.1.5 In the event of disputes between segments of the Medical Staff, then the matter in dispute shall be submitted to a Conflict Resolution Committee composed of an equal number of members representing opposing viewpoints who are appointed by the Chief of Staff or MEC. The

members of the Conflict Resolution Committee shall proceed in accordance with the paragraphs above.

14.1.6 If deemed appropriate by the Chief of Staff and the CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue between segments of the Medical Staff.

14.1.7 The Chief of Staff, the Hospital CEO, MEC or the Governing Body may at any time request that a Joint Conference Committee be convened to discuss any issues or disputes between the Governing Body and the Medical Staff. Any Joint Conference Committee shall consist of an equal number of members appointed by the Chair of the Governing Body and the Chief of Staff. The Joint Conference Committee shall consider such matters as are referred to it by the person or entity requesting appointment of the Committee and the Committee shall make its report and recommendations on such issues to the Governing Body and MEC. Any Joint Conference Committee which is appointed shall be automatically dissolved upon completion of the consideration of the issues presented to the Committee.

14.1.8 If deemed appropriate by the Chief of Staff and the Chairman of the Board, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue between the Medical Staff and the Governing Body.

ARTICLE XV

ADOPTION

15.1 Adoption of, and amendment to, these bylaws shall be as provided in Article XIII.

Revised & amended: 11/16/92; 11/15/93; 11/21/94; 5/15/95; 5/20/96; 8/19/96; 11/17/97; 3/15/99, 7/00, 5/2006, 2/2009, 3/2011, 5/11.

AUBURN REGIONAL MEDICAL CENTER

RULES AND REGULATIONS

R1.1 Admission and Discharge of Patients

R1.1.1 Patients are admitted to Auburn Regional Medical Center on the basis of medical need and without discrimination as to race, color, sex, or national origin.

R.1.1.2 Patients may be admitted and treated only by practitioners who have been granted appropriate privileges. It shall be the responsibility of the attending practitioner to see that each patient admitted to the Hospital receives a baseline history and physical examination.

R1.1.3 Patients shall be discharged only on order of the attending physician/oral surgeon or his designated alternate. At the time of discharge, the attending physician/oral surgeon shall see that the record is complete, state the final diagnosis, and sign the record.

R1.1.4 A physician or oralmaxillofacial surgeon holding privileges at the Hospital must complete a physical examination and medical history for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration. A history and physical must be completed prior to any surgery or procedure requiring anesthesia services. MEC may, at its discretion, specify in Medical Staff Policies additional privileged practitioners who may perform these required histories and physicals in accordance with state law and Hospital policy.

R2.1 Admissions Arranged Through the Emergency Services Department

R2.1.1 Patients applying for admission who have no attending physician/oral surgeon on the Hospital staff shall be assigned to the physician/oral surgeon on call for the Emergency Room at the time of admission. The on-call up physician/oral surgeon is responsible to either provide continuing care for the patient, or arrange for another member of the Medical Staff to provide appropriate care.

R2.1.2 If, for any reason, the on-call physician/oral surgeon cannot be reached within an appropriate time, the Emergency Physician is granted authority to call another physician/oral surgeon.

R2.1.3 The attending physician/oral surgeon will be notified when his patient requires admission to the Hospital. In cases of life-threatening emergency, it is the privilege of the Emergency Physician to admit the patient immediately to the Special Care Unit while arranging for the attending physician/oral surgeon, or his alternate, to be notified. The Emergency Physician takes full responsibility for the treatment of the patient until the attending physician/oral surgeon arrives.

R3.1 General Conduct of Care

R3.1.1 Consents

A. A general consent form, signed by, or as appropriate, on behalf of, every patient admitted to the Hospital must be obtained at the time of admission.

B. In addition, an authorization for surgical treatment must be signed by, or on behalf of, each patient scheduled for surgery not more than one month prior to treatment. This authorization assures the Hospital that the patient understands the reasons for the surgery and that the surgeon has explained its advantages and possible complications which may occur. Informed consent acknowledging the risks of any procedure or treatment is to be obtained by the practitioner.

C. In urgent, but not life-threatening emergencies, an effort must be made to obtain consent from the responsible party. Under such pressing situations, consent may be obtained by telephone from the parent or legal guardian, but it must be duly recorded and witnessed by a second member of the nursing staff.

D. When an emergency condition exists in which the life of the patient is in immediate danger, and in which any delay in administering treatment would increase the danger, necessary treatment may proceed without consent. Back-up staff should continue to attempt to contact the parent or legal guardian. The record should indicate the efforts made to obtain consent. A written consent should be obtained as soon as it is feasible.

R4.1 Surgery

R4.1.1 Surgery shall be performed only by physicians, oral surgeons, dentists and podiatrists who have been granted specific surgical privileges. The surgery performed shall be commensurate with those privileges granted.

R5.1 Patient Emergencies

R5.1.1 In the case of a condition in which the life of a patient is in immediate danger and in which any delay in administering treatment would increase the danger, and when the patient's attending practitioner or his designated alternate cannot be reached, the Chairman of the Department, the Chief of Staff, the Managing Director, or their alternates, shall have the authority to call any member of the Medical Staff, should he consider it necessary.

R5.1.2 An Emergency Physician will be on duty in the Hospital at all times.

R6.1 Mass Casualty Assignments

R6.1.1 The Managing Director, working with the Department of Emergency Services, shall provide a Mass Casualty Plan which shall adequately organize the Medical Staff, Nursing Staff, and other departments of the Hospital, to handle a mass influx of patients.

R6.1.2 The Managing Director, or, in his absence, the Assistant Administrator, Chief of Staff, or Chairman of the Department of Emergency Services, shall have the authority to implement the Mass Casualty Plan when appropriate.

R6.1.3 This plan for the care of mass casualties shall be rehearsed at least twice a year by key Hospital personnel.