STONEWALL JACKSON MEMORIAL HOSPITAL COMPANY

MEDICAL STAFF BYLAWS

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STONEWALL JACKSON MEMORIAL HOSPITAL COMPANY
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TABLE OF CONTENTS

Page(s)

PREAMBLE

WHEREAS, Stonewall Jackson Memorial Hospital Company ("Hospital") is a nonprofit corporation organized under the laws of the State of West Virginia; and

WHEREAS, it is recognized that the Medical Staff strives for patient care in Hospital at the generally recognized professional level of quality, that the Medical Staff is an independent self-governing component of Hospital, subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, hospital management and Board of Directors are necessary to fulfill the objective of providing the desired quality of care to its patients;

THEREFORE, the physicians, dentists, oral surgeons and podiatrists practicing in Hospital hereby organize themselves into a Medical Staff and shall carry out the functions delegated to the Medical Staff by the Board of Directors in conformity with these Bylaws.

DEFINITIONS

1. ADVANCED PRACTICE PROVIDER (APP) means an individual, other than a licensed physician, podiatrist, dentist, or oral surgeon, whose patient care activities require his/her authority to perform specified patient care services be processed through Medical Staff channels or with involvement of Medical Staff representatives. These individuals are not Members of the Medical Staff but may participate in committees and other Medical Staff activities as provided for by the Rules and Regulations, Policy, or other Medical Staff documents. These individuals are subject to Peer Review and Corrective Action but are not be afforded rights for hearings and appellate review as described by the Medical Staff Bylaws.

   Advanced Practice Providers may include members of the Independent Advanced Practice Provider Staff and members of the Dependent Advanced Practice Provider Staff (such as Physician Assistants (PA's); Certified Registered Nurse Practitioners (CRNP's); Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA's), and any others as designated by the System-wide Credentialing Office and as defined by the Rules and Regulations or other document approved by the Board of Directors to establish the procedures for evaluating requests for privileges by such Advanced Practice Providers.

2. BOARD OF DIRECTORS or BOARD means the Board of Hospital.

3. CHIEF ADMINISTRATIVE OFFICER (CAO) means the individual appointed by the board to act on its behalf in the overall management of the Hospital.

4. CLINICAL PRIVILEGES means the permission granted to a practitioner to admit, render specific diagnostic, and/or therapeutic medical, dental, and/or surgical services as defined by the practitioner's staff category and granted at the Hospital.

5. DAYS means calendar days, unless otherwise stipulated.

6. DENTIST means an individual who has been awarded the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

7. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

8. GOOD STANDING means the staff member, at the time the issue is raised, has met the attendance requirements during the previous appointment period, and has not received a suspension of his/her appointment or admitting privileges in the previous appointment period other than for medical record completion delinquency. The staff member should not be under corrective action.

9. HOSPITAL means Stonewall Jackson Memorial Hospital Company including all of its departments/ambulatory care settings.

10. HEALTH SYSTEM means the Monongalia Health System, Inc. and its related hospitals and affiliated entities.

11. MAJOR SPECIALTY and/or SUBSPECIALTY BOARD means:

- A certifying board, in the case of a physician, recognized by the American Board of Medical Specialties (ABMS)

- A certifying board recognized by the American Osteopathic Association (AOA), provided that the medical education and graduate medical education requirements are comparable to the respective ABMS Board.

- A certifying board, in the case of a dentist or an oral and maxillofacial surgeon, that requires completion of a residency program approved by the American Dental Association (ADA) Commission on Dental Accreditation.

- A certifying board, in the case of a podiatric surgeon, that requires completion of a surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

12. MEDICAL EXECUTIVE COMMITTEE (MEC) means the Executive Committee of the Medical Staff.

13. MEDICAL STAFF or STAFF means all licensed physicians, dentists, oral surgeons and podiatrists who are privileged to attend to patients in the Hospital.

14. MEDICAL STAFF LEADER means any Medical Staff officer, Chief Medical Officer, Vice President of Medical Affairs, Department Chief, Section Chief and Committee Chairperson.

15. MEDICAL STAFF SUPPORT SERVICES PERSONNEL means those individuals who support the Medical Staff with the appointment, reappointment and other administrative responsibilities associated with the Medical Staff operations.

16. MEDICAL STAFF YEAR means the period from January 1 to December 31.

17. MEMBER or MEMBERSHIP means the status of the physician, dentist, oral surgeon and podiatrist within the organization of the Medical Staff that has associated rights, obligations and responsibilities.

18. PATIENT CONTACTS include any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital or an affiliate including outpatient facilities or as determined by policy from time to time.

19. PHYSICIAN means an individual who has been awarded the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who maintains a current license.

20. PRACTITIONER means, unless otherwise expressly limited, any appropriately licensed physician, dentist, podiatrist, oral surgeon, or advanced practice provider, applying for Medical Staff membership/affiliation or clinical privileges/permission to practice at the Hospital; or, any Medical Staff member or advanced practice provider who has been granted privileges at the Hospital.

21. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these Bylaws approved by the Board of Directors.

22. PRIMARY AND SECONDARY HOSPITAL DESIGNATION means each member of the Medical Staff will have a primary and secondary hospital designation, if applicable.

23. QUALITY/UTILIZATION/PERFORMANCE IMPROVEMENT PROCESSES means those activities performed by members of the Medical Staff in committees, and at the department and Medical Executive Committee levels, to evaluate the quality, appropriateness, and efficiency of care rendered by all practitioners and Advanced Practice Providers. This can include Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) as well as hospital wide quality improvement initiatives and department specific quality improvement activities.

24. SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, or hand delivered to the addressee with a receipt or by overnight service delivery with a receipt or fax receipt.

25. SUPERVISING PHYSICIAN means a member of the Medical Staff who has agreed in writing to supervise or collaborate with an Advanced Practice Provider and accepts full responsibility for the actions of the Advanced Practice Provider while he or she is practicing in the Hospital.

26. SUPERVISION means the supervision of (or collaboration with) an Advanced Practice Provider by a supervising physician, that may or may not require the actual presence of the supervising physician, but that does require, at a minimum, that the supervising physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Advanced Practice Provider is credentialed and will be consistent with any applicable written supervision or collaborative agreement.

ARTICLE 1:
NAME

The name of this organization shall be the Medical Staff of Stonewall Jackson Memorial Hospital Company (the "Staff" or the "Medical Staff").

ARTICLE 2:
PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Staff are:

A. To be the formal organizational structure through which:

1. The benefits of membership on the Staff may be obtained by individual practitioners, and

2. The obligations of staff membership may be fulfilled.

B. To serve as the primary means for accountability to the Board of Directors for the quality and appropriateness of the professional performance and ethical conduct of its members and to strive toward providing patient care in the Hospital that is consistently maintained at the level of quality and efficiency that is in accordance with the generally accepted professional standards for such patient care in facilities of similar size and character.

C. To provide a means through which the Staff may participate in the Hospital's policymaking and planning process.

D. To support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

2.2 RESPONSIBILITIES

The responsibilities of the Staff, to be fulfilled through the actions of its officers, departments and committees, include:

2.2-1 To account for the quality and appropriateness of patient care rendered by all Medical Staff Members and Advanced Practice Providers authorized to practice in the Hospital through the following measures:

A. A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services

to be performed, with the verified credentials and current demonstrated performance of the applicant, staff member or Advanced Practice Provider;

B. A continuing education program, fashioned at least in part on the needs demonstrated through the quality/utilization processes program;

C. Utilization management processes to allocate inpatient and outpatient medical and health services based upon patient-specific determinations of individual medical needs;

D. An organizational structure that supports efforts to continuously monitor patient care practices;

E. Retrospective and concurrent review and evaluation of the quality of patient care through a valid and reliable quality-assessment process.

2.2-2 To recommend to the board action with respect to appointments, reappointments, staff category, departmental assignments, clinical privileges, and corrective action.

2.2-3 To account to the Board of Directors for the quality and appropriateness of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of the quality/utilization and performance improvement processes.

2.2-4 To initiate and pursue corrective action with respect to practitioners and Advanced Practice Providers, when warranted.

2.2-5 To develop, administer and seek compliance with these Bylaws, the Rules and Regulations of the Staff, and other patient-care-related Hospital policies.

2.2-6 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

2.2-7 To cooperate with and assist the Hospital in maintaining accreditation.

2.2-8 To establish and maintain Rules and Regulations for governance of the Medical Staff.

2.2-9 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE 3:
GENERAL PROVISIONS

3.1 STAFF RULES AND REGULATIONS

3.1-1 In coordination with the appropriate System-level Medical Staff Committee, the Medical Staff shall adopt such Rules and Regulations as may be necessary to more specifically implement the general principles of conduct found in these Bylaws. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with these standards. Rules and Regulations shall have the same force and effect as the Bylaws. If there is any inconsistency or ambiguity, the Medical Staff Bylaws have control over Rules and Regulations which have control over Policies.

3.2 CONFLICTS OF INTEREST

3.2-1 When performing a function outlined in the Bylaws or its related Rules and Regulations, if any Medical Staff Member or Practitioner has a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict will not participate in the discussion or voting on the matter, and will be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before being relieved of such duties.

3.2-2 Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict), or the applicable Department Chief or Committee Chairperson. The Chief of Staff or the applicable Department Chief or Committee Chairperson will make a final determination as to whether the provisions in this Article should be triggered.

3.2-3 The fact that a Department Chief or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

3.2-4 The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

3.3 INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, Department Chiefs, Committee Chairpersons, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

3.4 HEADINGS

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

3.5 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board of Directors shall be deemed so transmitted when delivered, unless otherwise specified, to the CAO of the Hospital.

3.6 TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

3.7 DESIGNEES TO PERFORM FUNCTIONS OF THE CAO

Any responsibility assigned, or authority granted, to the CAO of the Hospital, a Medical Staff Member, or by a Medical Staff Committee may be fulfilled or exercised by another administrative official of the Hospital, designated by the individual or committee assigned such responsibility or by the Board of Directors to perform such function, except as otherwise provided by the Board of Directors or in the Hospital Bylaws.

3.8 GOOD STANDING

The prerogatives and rights provided by these Bylaws to Medical Staff Members to vote at medical staff meetings, to be nominated for and to hold medical staff office or service as a member of the Medical Executive Committee, and to serve as a Department Chief, or Section Chief, or Committee Chairperson, shall be limited to Medical Staff Members in good standing.

3.9 SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

ARTICLE 4:
CONFIDENTIALITY, IMMUNITY AND RELEASE

4.1 SPECIAL DEFINITIONS

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

A. INFORMATION means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, date and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 4.4-2.

B. MALICE means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

C. REPRESENTATIVE means the Board of Directors and any member or committee thereof, the CAO of the Hospital and other management staff, the staff organization and any member, officer, department or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

D. THIRD PARTIES means, both individuals and organizations providing information to any representative.

4.2 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the practitioner, or used in any way except as provided in this Article. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Hospital records.

Actions taken and recommendations made pursuant to these Bylaws will be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities will make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

A. when the disclosures are to another authorized member of the Medical Staff, Board, legal counsel representing the Hospital, or authorized Hospital employee, and are for the purpose of conducting legitimate credentialing and peer review activities;

B. when the disclosures are authorized by a Medical Staff or Hospital policy; or

C. when the disclosures are authorized, in writing, by the CAO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

4.3 IMMUNITY FROM LIABILITY

4.3-1 For Action Taken

No representative of the Medical Staff or Hospital shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice. Regardless of any rule of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

4.3-2 For Providing Information

No representative of the Medical Staff or Hospital and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Medical Staff or Hospital or to any other hospital, organization of health professionals, or other health-related or educational institution or organization concerning a practitioner who is or has been an applicant to or member of the Medical Staff or who did or does exercise clinical privileges at this Hospital, provided that such representative or third party acts in good faith and without malice.

4.4 ACTIVITIES AND INFORMATION COVERED

4.4-1 Peer Review Activities

A. All credentialing and peer review activities pursuant to these Bylaws and related Medical Staff documents will be performed by "Review Organizations" in accordance with W.Va. Code. Review organizations include, but are not limited to:

1. all standing and ad hoc Medical Staff and Hospital committees;

2. all departments and sections;

3. hearing panels;

4. the Board and its committees; and

5. any individual acting for or on behalf of any such entity, including but not limited to Department Chiefs, Section Chiefs, Committee Chairpersons and members, officers of the Medical Staff, Vice President of Medical Affairs, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by review organizations are confidential and covered by the provisions of applicable state law.

B. All review organizations will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, found in the United States Code.

4.4-2 Activities

In addition to the protections for peer review activities under West Virginia law, the confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

A. Applications for appointment and clinical privileges,

B. Periodic reappraisals for reappointment and clinical privileges,

C. Corrective action,

D. Hearings and appellate reviews,

E. Quality assessment and performance improvement activities,

F. Utilization reviews,

G. Malpractice loss prevention, and

H. Other Hospital, department, committee and subcommittee activities related to monitoring and evaluation of the quality and appropriateness of patient care and professional conduct.

4.4-3 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

4.5 RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, 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 the State of West Virginia, and

such releases or copies thereof may be submitted to third parties from whom information as described in Section 4.5-2 is sought.

4.6 CUMULATIVE EFFECT

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

ARTICLE 5:
MEDICAL STAFF MEMBERSHIP

5.1 NATURE OF STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent physicians, dentists, oral surgeons and podiatrists 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 Medical Staff Member only such clinical privileges and prerogatives as have been granted by the Board of Directors in accordance with these Bylaws, and shall include staff category and department assignments.

5.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

5.2-1 Basic Qualifications

To be eligible to apply for appointment and clinical privileges, an individual must:

A. Have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

B. Document their experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board of Directors that they will provide care to patients at the generally recognized professional level of quality, in an efficient manner, taking into account patients' needs and the available Hospital facilities and resources, consistent with the utilization standards in effect at the Hospital,

C. As determined on the basis of documented references, adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities,

D. Maintain professional liability insurance coverage in form and in amounts satisfactory to the Hospital, with additional tail insurance coverage for any claims-made

insurance policies to cover any future claims arising from the individual's practice at the Hospital after termination of the policy,

E. Where applicable to the practitioner, have a current unrestricted DEA registration. For example, DEA registration is not required for a pathologist or a radiologist whose clinical privileges are not affected by the lack of a DEA certificate.

F. Be located (office and residence) within the geographic services area of the Hospital, as defined by the Board of Directors, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in Hospital,

G. Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payor program fraud or abuse, nor have been required to pay civil monetary penalties for the same,

H. Have never been, and are not currently, excluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program,

I. Have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation,

J. Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or related to the practitioner's suitability to practice medicine,

K. Agree to fulfill all responsibilities regarding emergency call,

L. Demonstrate willingness and capability to abide by all Medical Staff and Hospital Bylaws, Rules and Regulations, policies and procedures, including but not limited to adherence to generally recognized standards of professional and personal ethics and conduct.,

M. Have coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable,

N. Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those individuals who apply for initial staff appointment on or after the date of adoption of these Bylaws.),

O. Demonstrate recent clinical activity in their primary area of practice during at least two of the last four years or engaged in medical education related activities (i.e. residency, fellowship),

P. Demonstrate current clinical privileges are not currently suspended at any other Hospital,

Q. Is not applying for privileges in a service which is currently under a moratorium, unless they are either directly employed by Hospital or employed or contracted through a group which has a contract to provide the clinical services to the Hospital,

R. Be qualified for Membership on the Staff and demonstrate their willingness to participate in the discharge of Medical Staff obligations and responsibilities.

When the Medical Executive Committee or Board of Directors has reason to question the physical and/or mental health status of an applicant, the applicant shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee or Board of Directors, as a prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her staff appointment.

5.2-2 Specialty Status

A. Except as expressly set forth in Section 5.2-2 C below, obtaining and maintaining specialty board certification is required for all Medical Staff Members. However, physicians and dentists who have recently completed their residency training may become members of the medical staff if they have satisfied all of the requirements to sit for the certifying exam as defined by their specialty board and thereafter obtain certification within the earlier of (i) the time frame mandated by the American Board of Medical Specialties ("ABMS"), AOA or ADA or (ii) within 5 years of the completion of residency training. If a physician or dentist fails to obtain board certification in the required time frame, such physician or dentist will be ineligible for medical staff privileges and physicians and dentists who are members of the medical staff will be deemed to have voluntarily relinquished his or her privileges effective as of the expiration of the time frame.

Except as expressly set forth in Section 5.2-2 C below, all Medical Staff Members are required to maintain board certification in accordance with the requirements of ABMS, AOA or ADA. If a physician or dentist fails to maintain his or her specialty board certification, such physician or dentist will be deemed to have voluntarily relinquished his or her privileges on the day of expiration of certification.

B. The Board of Directors may grant waivers of the requirements in A. above after recommendations for granting such a waiver have been made by the relevant department chief and the Medical Executive Committee. When granting a waiver, the Board of Directors shall document the circumstances and conditions of the Waiver. A decision by the Board of Directors not to grant a waiver shall not create a basis for the rights to a hearing or appellate review provided in these Bylaws, including those provided in Articles 8 and 16.

C. The requirements of the above paragraph do not apply to any practitioner who was a Medical Staff Member on or before July 1, 2021 and has remained on the Medical Staff continuously since such date.

5.2-3 Waiver of Criteria

A. Any individual who does not satisfy one or more of the criteria outlined in Sections 5.2-1 or 5.2-2 may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

B. A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant Department Chief, and the best interests of Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such.

C. The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

D. No individual is entitled to a waiver or to a hearing if the Board of Directors determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

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

F. An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

5.2-4 Effect of Other Affiliations

No physician, dentist, oral surgeon or podiatrist is entitled to membership on the Medical Staff or to the exercise of particular clinical privileges solely because he/she is licensed to practice in this or in any state, or because he/she is a member of any professional organization, or is certified by any specialty or professional board, presently or formerly held medical staff membership or privileges at another health care facility or in another practice setting, resides in the geographic service area of Hospital, or is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

5.2-5 Nondiscrimination

Medical Staff membership or particular clinical privileges shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the Hospital, including, but not limited to, gender, race, creed, color and national origin.

5.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

5.3-1 As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

A. To provide continuous and timely care to all patients for whom the individual has responsibility at the generally recognized professional level of quality and efficiency;

B. To abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

C. To accept and discharge committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality and performance improvement and peer review activities, and such other reasonable duties and responsibilities as assigned and consistent with his/her granted clinical privileges;

D. To comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

E. To also comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

F. To inform the CAO and the Chief of Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

G. To immediately submit to a blood and/or urine test, any pertinent type of health evaluation, or to a complete physical and/or mental evaluation, as requested by an

Officer of the Medical Staff, Chief Medical Officer, Vice President of Medical Affairs, CAO, or Department Chief when it appears necessary to protect the well-being of patients and/or staff, when there is concern with the individual's ability to safely and competently care for patients, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the Medical Staff and Hospital policies addressing physician health or impairment. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff leadership;

H. To appear for personal interviews in regard to an application for initial appointment or reappointment, if requested;

I. To use the Hospital sufficiently to allow continuing assessment of current competence;

J. To refrain from illegal fee splitting or other illegal inducements relating to patient referrals;

K. To refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

L. To refrain from deceiving patients as to the identity of any individual providing treatment or services;

M. To seek consultation whenever necessary;

N. To complete in a timely manner all medical and other required records. Evidence of a medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Details of requirements for completing a history and physical for inpatient and outpatient settings are found in the Rules and Regulations;

O. To maintain confidentiality of peer review and protected health information in accordance with law, Hospital policies and the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

P. To provide services to meet individual needs of patients seeking services in the Hospital regardless of their ability to pay, in accordance with Hospital and Medical Staff policies;

Q. To perform all services and conduct himself/herself at all times in a cooperative and professional manner;

R. To promptly pay any applicable assessments and/or fines;

S. To satisfy continuing medical education requirements; and

T. That any misstatement in, or omission from the application, is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there will be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board whether the application should be processed further.

U. To authorize representatives of the Medical Staff and the Hospital to solicit, provide and act upon information bearing on his/her professional ability and other qualifications.

V. 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.

W. To acknowledge the provisions of this Article are express conditions to the application for, or acceptance of, staff membership, or his/her exercise of clinical privileges at this Hospital.

X. Each Medical Staff member must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate the member's clinical privileges.

Y. Prior to admittance to Medical Staff and regularly thereafter as required, each Medical Staff Leader shall promptly disclose to the Hospital Compliance Department any conflicts of interest with the interests of the Medical Staff, the Hospital, and Health System.

5.3-2 Additional Conditions for Reappointment.

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment. To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term as well as all qualifications under FPPE and OPPE Policies and any other Medical Staff Policy or Policies and shall continue to meet all qualifications and criteria for appointment and the clinical privileges requested.

5.3-3 Factors for Consideration in Appointment and Reappointment

A. Appointment Generally. Only those practitioners who can document they are highly qualified in all regards, and have, within the last 12 months, been engaged in active clinic practice or engaged in medical education related activities, will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

1. Relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided,

2. Preferred but not required to be board certified in their primary area of practice at the Hospital,

3. Adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession,

4. Good reputation and character,

5. Ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams,

6. Ability to safely and competently perform the clinical privileges requested; and

7. Recognition of the importance of, and willingness to support, Hospital's commitment to quality care and a recognition that interpersonal skills, good citizenship, and collegiality are essential to the provision of quality patient care.

8. Their privileges at another hospital or health care entity are not at the time of application under suspension.

9. They have not been excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or, convicted of a criminal offense related to the provision of health care.

10. Their license to practice has not been revoked in any state or is not at the time of application under suspension.

11. They currently have professional liability insurance or have applied for professional liability insurance in the amount specified by the Board.

12. They have established or plan to establish an office and residence within established distance of the Hospital to provide coverage, if applicable.

13. They are licensed to practice or have applied to be licensed to practice in West Virginia, and/or the state in which they will practice, if applicable.

B. Reappointment. In addition to the general factors considered in appointment, candidates for reappointment shall be evaluated in light of the following:

1. compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

2. participation in Medical Staff duties, including committee assignments and emergency call;

3. the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

4. any focused professional practice evaluations;

5. verified complaints received from patients and/or staff; and

6. other reasonable indicators of continuing qualifications.

5.4 NATURE AND DURATION OF APPOINTMENTS

5.4-1 Provisional Appointments

A. All initial appointments to the Medical Staff, regardless of staff category, and changes to staff category or granting of additional privileges shall be provisional and subject to focused professional practice evaluation. Each provisional appointee shall be assigned to a department where his/her performance shall be observed on an ongoing basis by the Department Chief and/or by a physician(s) designated by the Credentials Committee to determine the applicant's eligibility for regular medical staff category to which he/she was provisionally appointed and for exercising the clinical privileges provisionally granted. While on provisional status an appointee shall not be eligible to vote or hold office. This shall be a six month to twelve-month period, or as recommended by the Credentials Committee. The number and types of cases to be reviewed shall be determined by the Credentials Committee.

In the event of a change in contract provider for any Hospital based department and the Department Chief is hereby initially appointed to the medical staff, such Department Chief shall have the right to vote.

B. During the provisional period the appointee will meet all the Rules and Regulations of the Medical Staff prior to his/her elevation to full medical staff status.

C. During the period of provisional status, an evaluation of the performance of each provisional Medical Staff Member will be carried out by or under the direction of the Chief of the Department in which the individual has clinical privileges and/or by a physician designated by the Credentials Committee in accordance with established department criteria and/or policy.

1. Each provisional Medical Staff Member shall participate in an appropriate number of cases as determined by the Department Chief (subject to the Credentials Committee approval in accordance with Section 5.4-1A), cooperate in monitoring and review conditions, and otherwise fulfill all requirements of appointment including but not limited to the

timely completion of medical records and/or emergency service call responsibilities if applicable. Any provisional Medical Staff Member whose Membership is terminated or who otherwise does not advance due to failure to meet such conditions shall be ineligible to reapply for initial appointment or privileges for a period of two years.

2. If a member of the Medical Staff has been granted additional clinical privileges fails, during the provisional period, to participate in an appropriate number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, unless an extension is granted. The individual may not reapply for the privileges in question for two years.

3. At the end of this time, if the appointee fails within such period to fulfill the requirements for advancement from provisional status, his/her Medical Staff Membership or particular clinical privileges, as applicable, shall automatically terminate, unless extended. If the practitioner is deemed to have insufficient experience to advance to full medical staff status, the period of provisional status may be extended if recommended by the Department Chief, and/or designated preceptor and ultimately accepted and approved by the Credentials Committee. The appointee whose provisional status is automatically terminated shall be given Notice of such termination and shall be entitled to the procedural rights afforded in Article 12. When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights afforded in Article 12.

5.4-2 Reappointments

A. Reappointments to the Medical Staff shall be for a period of no more than two (2) years. The period of reappointment shall be specified in the notice of reappointment.

B. Reappointments to the Medical Staff shall be made in a manner that will bring the practitioner within the regular reappointment processing cycle.

C. Upon written request, practitioners who have reached the age of seventy-five (75) years and desire to continue to exercise clinical privileges shall be granted reappointments for periods not exceeding one (1) year.

5.4-3 Modifications of Appointments

Any modification of appointment or clinical privileges shall be for the period stated in the action approving such modification.

5.4-4 Contract Practitioners

The medical staff appointment and clinical privileges of any staff member who has a contractual relationship with the Hospital, or is either an employee, or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon:

A. The expiration or other termination of the contractual relationship with the Hospital, or

B. The expiration or other termination of the relationship of the Medical Staff Member with the entity that has a contractual relationship with the Hospital.

When the services rendered to patients by the Medical Staff Member, in connection with a contractual relationship as described above, are less extensive than the services the staff member may render in conformity with the clinical privileges awarded to him/her, the automatic termination shall apply only to the clinical privileges related to the services covered by the contractual relationship, and the staff member's medical staff appointment and remaining clinical privileges shall continue in effect as long as they satisfy all of the other conditions and Rules and Regulations for continued appointment.

In the event of such termination of medical staff appointment and/or clinical privileges, no rights to a hearing or appellate review provided in these Bylaws, including those provided in Articles 12 and 13 shall apply.

5.5 LEAVE OF ABSENCE

5.5-1 An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CAO, Chief Medical Officer, or Vice President of Medical Affairs. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

5.5-2 Members of the Medical Staff must report to the CAO any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CAO, in consultation with the Chief of Staff, may trigger an automatic leave of absence.

5.5-3 The CAO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CAO will consult with the Chief of Staff and the relevant Department Chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

5.5-4 During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

5.5-5 Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant Department Chief, the Chairperson of the

Credentials Committee, the Chief of Staff, and the CAO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff Member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

5.5-6 If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a Hospital practice and safely exercising the clinical privileges requested.

5.5-7 Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CAO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

5.5-8 If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will lapse at the end of the appointment period, and the individual will be required to apply for reappointment.

5.5-9 Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

ARTICLE 6:
CATEGORIES, ADMISSION, AND CREDENTIALING OF THE MEDICAL STAFF

6.1 OVERVIEW

The Medical Staff shall be divided into active, courtesy, outpatient affiliate, consulting, emeritus, retired and telemedicine status. The categories of the Medical Staff are related to membership on the Medical Staff and are independent of clinical privileges. There are also individuals who may be exercising privileges granted through the Medical Staff process who are not members such as APPs. All processes for application for admission to the Medical Staff, associated credentialing, delineation of qualifications, prerogatives, and responsibilities shall be managed by the System-wide Credentialing Office. After appropriate review, the candidates for admission to the Medical Staff shall be provided to the Medical Executive Committee for approval.

6.2 ACTIVE STAFF

6.2-1 Qualifications

The active staff shall consist of physicians, dentists, oral surgeons and podiatrists, each of whom:

A. Meets the basic qualifications set forth in Section 5.2-1 and 5.2-2 and any others promulgated by the System-wide Credentialing Office,

B. Are involved in at least 12 patient contacts per appointment term.

6.2-2 Prerogatives

The prerogatives of an active Medical Staff Member shall be to:

A. A physician member may admit patients to the inpatient setting of the Hospital according to his/her privileges.

B. Exercise such clinical privileges as are granted to him/her pursuant to Article 13.

C. Vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings;

D. Hold office, serve as Department Chiefs and serve on committees; and

E. Be entitled to priority scheduling for non-emergency/elective patients for the operating room and outpatient services.

6.2-3 Responsibilities

A. Each member of the active staff shall:

1. Fulfill the basic responsibilities set forth in Section 5.3,

2. Retain 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, or arrange a suitable alternative for such care and supervision,

3. Actively participate in the peer review and quality/utilization/performance improvement processes required of the Medical Staff in monitoring new appointees of his/her same profession, in serving on Emergency Department call rosters, if eligible, except as exempted by his/her clinical department, accept consultations when requested and in discharging such other medical staff functions as may from time to time be required,

B. Members of the Active Staff who are at least 60 years of age and have served on the Active Staff for at least 15 years may request removal from emergency call and other rotational obligations, unless they are bound under a conflicting term in a contractual agreement with the Hospital. The Department Chief and Section Chief (as applicable), shall recommend to the Medical Executive Committee whether to grant these requests based on need and the effect on others who serve on the call roster for that specialty. The Medical Executive Committee's recommendation shall be subject to final action by the Board.

6.3 COURTESY STAFF

6.3-1 Qualifications

A. The courtesy staff shall consist of physicians, dentists, oral surgeons and podiatrists, each of whom either:

1. Meets the basic qualifications set forth in Sections 5.2-1 and 5.2-2, and holds an active Medical Staff appointment at another accredited hospital as their primary hospital and any others promulgated by the System-wide Credentialing Office; or

2. Meets the basic qualifications set forth in Section 5.2-1 and 5.2-2, and is involved in no more than 6 patient contacts per year (involvement in a greater number of patient contacts shall result in automatic transfer to the Active Staff) and any others promulgated by the System-wide Credentialing Office.

B. At each reappointment time, each Courtesy Staff member must provide evidence of clinical performance at their primary hospital in such form as may be requested. In addition, especially for those Courtesy Staff members who do not maintain a primary appointment at another hospital, they shall provide other information as may be required in order to perform an appropriate evaluation of qualifications (including, but not limited to, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

6.3-2 Prerogatives and Responsibilities

Courtesy Staff members:

A. shall discharge the basic responsibilities specific in Section 5.3;

B. shall retain 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, or arrange a suitable alternative for such care and supervision;

C. may attend and participate in Medical Staff and department meetings (without vote);

D. may not hold office or serve as Department Chiefs or Committee Chairpersons;

E. may be invited to serve on committees (with vote);

F. are excused from emergency call and care of unassigned patients unless the Medical Executive Committee finds that there are insufficient Active Staff members in a particular specialty; and

G. shall cooperate in the peer review and performance improvement process.

6.4 OUTPATIENT AFFILIATE STAFF

6.4-1 Qualifications

A. The Outpatient Affiliate Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who desire to be associated with the Hospital and who request Hospital services for their patients. The primary purpose of the Outpatient Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals access to Hospital services for their patients, for example physicians who desire to be associated with the Hospital for the purpose of ordering services at the Hospital Infusion Center for their patients.

B. Physicians requesting appointment to the Outpatient Affiliate Staff must submit an application for appointment or reappointment as prescribed in policy by the System-wide Credentialing Office, but are not required to satisfy the qualifications set forth in Section 5.2-1K but are required to meet any other qualifications promulgated by the System-wide Credentialing Office.

6.4-2 Prerogatives and Responsibilities

A. Except as detailed by the System-wide Medical Staff Credentials Committee Outpatient Affiliate Staff members may not admit patients to the inpatient setting of the Hospital, exercise inpatient clinical privileges, write inpatient medical orders, provide

inpatient consultation, or otherwise participate in the provision or management of clinical care to inpatients at the Hospital.

B. Outpatient Affiliate Staff members:

1. may refer patients to the Hospital's diagnostic facilities and order diagnostic tests;

2. may refer patients to members of the Active Staff for admission and/or care;

3. may visit their hospitalized patients and review the medical record and outpatient infusion records for their patients via paper or electronic access;

4. may attend Medical Staff meetings and educational activities sponsored by the Medical Staff and the Hospital; and

5. may serve on Medical Staff committees, with vote, if requested, but may not serve as a Committee Chairperson.

C. Outpatient Affiliate Staff members may be privileged to write medical orders for their patients for services at the Hospital Outpatient Infusion Center. The ordering physician must be available to follow up on his or her patients on site if requested by the infusion therapist, the Infusion Center Director, the Vice President of Medical Affairs or Chief of Staff or a designee, and must be located within the geographic service area of the Hospital, as defined by the Board, close enough to provide timely and continuous care for his or her patients at the Hospital Outpatient Infusion Center. If privileged to do so the Outpatient Affiliate Staff Member:

1. may perform office history and physical examination and have that report entered into the patient's outpatient medical record;

2. may communicate at any time directly with the infusion therapist concerning the infusion order and care of their patients;

3. shall cooperate as requested in the peer review, outpatient professional practice evaluation and performance improvement activities and process

D. Outpatient Affiliate Staff members may not vote, hold Medical Staff office, or serve as Department or Section Chief.

6.5 CONSULTING STAFF

6.5-1 Qualifications

The Consulting Staff shall consist of practitioners of recognized professional ability and expertise who provide a service that is not available on the Active Staff and are appointed to the Active Staff at another hospital where they are currently practicing. At the time of initial

appointment and at each reappointment time, they must provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges and meet any other qualifications promulgated by the System-wide Credentialing Office.

6.5-2 Prerogatives and Responsibilities

Consulting Staff members:

A. may treat (but not admit patients to the inpatient setting of the Hospital) patients in conjunction with another physician on the Active Staff;

B. may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

C. may not hold office or serve as Department Chiefs or Committee Chairpersons; and

6.6 EMERITUS STATUS

6.6-1 Qualifications

The Emeritus Staff shall consist of practitioners who have reached the age of 60 years and have served as members of the Active Staff for at least 15 years, and who request transfer to the Emeritus Staff and meet any other qualifications promulgated by the System-wide Credentialing Office.

6.6-2 Prerogatives

Emeritus Staff members shall have the same prerogatives as Active Staff members, but shall not be required to attend meetings, hold office, or take call unless the Medical Executive Committee finds that there are insufficient members in a particular specialty to adequately cover the call schedule.

6.7 RETIRED STAFF

6.7-1 Qualifications

The Retired Staff shall consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long-standing service to the Hospital, and have retired from the active practice of medicine and meet any other qualifications promulgated by the System-wide Credentialing Office.

6.7-2 Prerogatives and Responsibilities

Retired Staff members may:

A. not consult, admit or attend to patients to the inpatients in the Hospital setting;

B. attend staff and Department meetings when invited to do so (without vote);

C. be appointed to committees (with vote); and

D. not vote, hold office, serve as a department chief.

6.8 TELEMEDICINE STAFF

4.7-1 Qualifications

The Telemedicine Staff shall consist of physicians, each of whom are currently practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by CMS and/or The Joint Commission. Such appointment shall be limited by the applicable Medical Staff policy, Rules and Regulations and shall carry no admitting privileges and they must meet any other qualifications promulgated by the System-wide Credentialing Office. Credentialing and privileging Providers of telemedicine services may be fulfilled by written agreement with a Hospital contracted or telemedicine entity in which the provider has been fully privileged and credentialed in accordance with Medical Staff Bylaws and Policies. Members of the Telemedicine Staff will be placed in other staff categories if they provide patient care services while physically located at the Hospital.

4.7-2 Prerogatives and Responsibilities:

A telemedicine staff member may:

A. treat patients via electronic communication link, except set forth in department rules and regulations, privilege criteria and Hospital policies;

B. exercise such clinical privileges as granted;

C. may not hold office;

D. may not participate in committees or serve as committee chair and may not vote;

E. are excused from providing specialty coverage for the ED for unassigned patients except as required under the contract with Hospital; and

F. must participate in Performance Improvement and OPPE processes.

6.9 CLINICAL COVERAGE PROVIDERS

6.9-1 Qualifications:

A. The Clinical Coverage Providers shall consist of any licensed physician, such as such as a Resident or Fellow, employed or contracted part time by the Hospital to perform duties in a specialty under the supervision of specific Members of the Medical Staff,

but who perform these duties outside the scope of an approved residency or fellowship program.

B. Only Clinical Coverage Providers holding a license, certificate or other credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board;

C. Clinical Coverage Providers shall meet the basic qualifications set forth in Sections 5.2-1 except K., N., R., and any others delineated by Medical Staff Rules Regulations, and Policies; and

D. Provided a needed service within the hospital.

6.9-2 Prerogatives and Responsibilities:

A. may exercise those specified privileges in the Hospital as delineated by the MEC and approved by the Board;

B. shall be appointed to a specific department and be approved in advance by the Chief of the Department in which they work;

C. shall meet the CME requirements of the Medical Staff or be enrolled in an approved residency or fellowship program;

D. may attend Medical Staff, Department, and Section meetings when invited to do so (without vote); and

E. may not be eligible to hold office, serve as a Department Chief, section/division chief or committee chair of a Medical Staff committee.

6.10 ADVANCED PRACTICE PROVIDERS

6.10-1 Qualification

A. The Advanced Practice Providers shall consist of any individual, other than a licensed physician, podiatrist, dentist, or oral surgeon, who are granted privileges to practice in the Hospital and are directly involved in patient care. Such individuals may be employed by physicians on the medical staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician who maintains clinical privileges to perform procedures in the same specialty area as the APP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations);

B. Only APPs holding a license, certificate or other credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board;

C. APPs shall meet the basic qualifications set forth in Sections 5.2-1 except K., N., R., and any others delineated by Medical Staff Rules Regulations, and Policies;

D. Document their professional experience, background, education, training, demonstrated ability, current competence, and physical and mental status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care that they are qualified to provide needed services within the hospital;

E. Establish on the basis of documented references, they adhere strictly to the ethics of the respected profession, work collaboratively with others, and are willing to participate in the discharge of APP responsibilities;

F. Provided a needed service within the hospital; and

G. Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the APP and the responsibility for directing and supervising the APP.

6.10-2 Prerogatives

A. To exercise judgment within the APP's area of competence, providing that a physician Member of the Medical Staff has the ultimate responsibility for patient care;

B. To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a Member of the Medical Staff; and

C. To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required, and to discharge such other functions as may be required from time to time.

6.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a physician's or dentist's staff appointment, by other sections of these Bylaws, by the Rules and Regulations of the Staff, or by policies of the Hospital.

ARTICLE 7:
OFFICERS OF THE MEDICAL STAFF AND DEPARTMENTS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1-1 The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, and Immediate Past Chief of Staff.

7.1-2 Qualifications

A. Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. Officers must:

1. be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years;

2. have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

3. not presently be serving as Medical Staff officers, or Board Members, or Department Chief at any other hospital outside the Health System, and shall not so serve during their terms of office;

4. be willing to faithfully discharge the duties and responsibilities of the position;

5. have experience in a leadership position, or other involvement in performance improvement functions for at least two years;

6. attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

7. have demonstrated an ability to work well with others; and

8. not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

7.1-3 Nominations

The Chief of Staff shall nominate one or more qualified nominees for the office of Secretary-Treasurer. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least ten days prior to the election. In order for a nomination to be placed on the ballot the candidate must meet the qualifications in Section 7.1-2. Nominations from the floor shall not be accepted.

7.1-4 Election

Officers and committee members for whom election is required shall be elected at the annual meeting of the Medical Staff. Only Medical Staff Members in good standing may vote and voting shall be by secret written ballot in the event there is more than one nominee for an office or committee position.

Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office or committee position 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.

7.1-5 Terms of Elected Office

Officers shall serve for a term of one year or until a successor is elected pursuant to this Article 7.

7.1-6 Removal of Officers

A. Removal of an elected officer or a member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Executive Committee, subject to Board confirmation; or by the Board for:

1. failure to comply with applicable policies, Bylaws, or Rules and Regulations;

2. failure to perform the duties of the position held;

3. conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

4. an infirmity that renders the individual incapable of fulfilling the duties of that office.

B. At least ten days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board prior to a vote on removal.

7.1-7 Vacancies in Staff Offices

A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff, who shall serve until the end of the Chief of Staff's unexpired term and then shall assume the role of Chief of Staff for his or her own one-year term. In the event there is a vacancy in the Vice Chief of Staff position, the Secretary/Treasurer will fill the position of Vice Chief of Staff and, at the conclusion of that term shall go on to assume the role of Vice Chief of Staff for his or her own one-year term. When the office of Secretary/Treasurer is vacant, the Medical Executive Committee shall appoint an individual to fill the office of Secretary/Treasurer for the remainder of the term or until a special election can be held, in the discretion of the Medical Executive Committee.

7.1-8 Duties of Elected Officers

A. Chief of Staff: The Chief of Staff shall:

1. act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

2. represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the CAO, Vice President of Medical Affairs and the Board;

3. call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;

4. appoint all Committee Chairpersons and committee members (who may include Medical Staff Members, Advanced Practice Providers, and others), in consultation with the Medical Executive Committee;

5. Chairperson the Medical Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, ex officio, without vote;

6. promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

7. recommend Medical Staff representatives to Hospital committees;

8. perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy for Medical Staff Members; and

9. serve on the Medical Executive Committee at the conclusion of his/her term as the Immediate Past Chief of Staff.

B. Vice Chief of Staff:

1. assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

2. serve on the Medical Executive Committee;

3. assume all such additional duties as are assigned to him or her by the Chief of Staff or the Medical Executive Committee; and

4. upon approval of the Medical Executive Committee, assume the role of Chief of staff at the conclusion of his or her term as Vice Chief of Staff.

C. Secretary-Treasurer: The Secretary-Treasurer shall:

1. serve on the Medical Executive Committee;

2. if applicable, be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff; and

3. upon approval of the Medical Executive Committee, assume the role of Vice Chief of staff at the conclusion of his or her term as Secretary-Treasurer.

7.2 VICE PRESIDENT OF MEDICAL AFFAIRS

The Vice President of Medical Affairs shall be appointed by the CAO, with advice from the Medical Executive Committee, and shall be responsible to the CAO as the Vice President of Medical Affairs of the Hospital. The Vice President of Medical Affairs shall perform such duties and functions as may be delegated from time to time by the CAO, which may include but not be limited to the following:

A. assisting the CAO in the implementation of the Hospital's performance improvement program;

B. serving as an ex officio member of all departments and all Medical Staff committees;

C. serving as an advisor to the Medical Staff and the Chief of Staff for proper staff organization and Bylaws;

D. assisting Department Chiefs in the performance of their duties;

E. actively participating in the preparation and presentation of budgets for each department in conjunction with Hospital management;

F. acting as the Hospital's medical liaison, after consultation with the CAO, to local, state and federal agencies;

G. assisting the CAO in the supervision and direction of all Hospital-based physicians;

H. endeavoring to maintain accreditation status;

I. coordinating all of the medical education activities within the Hospital; and

J. serving as liaison to all academic affiliations of the Hospital.

ARTICLE 8:
MEDICAL STAFF DEPARTMENTS

8.1 ORGANIZATION OF MEDICAL STAFF DEPARTMENTS

The Medical Staff shall be organized into the departments. Subject to the approval of the appropriate System-level Medical Staff Committee and the Board, the Medical Executive Committee may create new departments, eliminate departments, create sections within

departments, or otherwise reorganize the department structure as may be necessary for the orderly conduct of the Medical Staff work.

8.2 DEPARTMENTS

8.2-1 Current Departments

The following clinical departments are established. In addition, the corresponding sections may be established as applicable:

- Department of Medicine
- Department of Surgery
- Department of Radiology

8.3 ASSIGNMENT TO CLINICAL DEPARTMENTS

Upon initial appointment to the Medical Staff, each member shall be assigned to at least one clinical Department. Assignment to a particular Department does not preclude an individual from seeking and being granted clinical privileges typically associated with another Department. An individual may request a change in Department assignment to reflect a change in the individual's clinical practice.

8.4 FUNCTIONS OF CLINICAL DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by members of the department, to include possible peer review related inquiries. To carry out this responsibility, each department shall:

A. To participate in the quality and utilization processes for the purpose of reviewing and evaluating the quality and appropriateness of care within the department to include:

1. The identification of the important aspects of care for the department and the indicators used to monitor the quality and appropriateness of the important aspects of care, as part of its review of the quality and appropriateness of care provided under its jurisdiction.

2. Receipt of reports which allows review and analysis of the following:

(i) Where applicable, discrepancies between preoperative, postoperative and pathological diagnosis.

(ii) Procedures where there is a question of applicability for particular clinical diagnosis.

(iii) Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

B. Establish guidelines for evaluating requests for clinical privileges within the department and submit assessments of qualifications regarding the specific privileges each Medical Staff Member or applicant may exercise,

C. Conduct or participate in continuing education programs,

D. Monitor adherence to:

1. Medical staff and hospital policies and procedures,

2. Requirements for alternate coverage and for consultations,

3. Sound principles of clinical practice based on agreed upon objective criteria that reflect current knowledge and experience, and

4. Hospital-wide safety programs.

E. Coordinate the patient care provided by the department's members with nursing and other professional patient care services and with administrative support services.

F. Submit written reports to the Medical Executive Committee on a regularly scheduled basis.

G. Meet as frequently as needed for the purposes of receiving, reviewing and considering findings of the quality/utilization processes and the results of the department's review, evaluation and education activities and of performing, or receiving reports on, other department and medical staff functions;

H. Develop proposals for Rules and Regulations; and

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

8.5 QUALIFICATIONS OF DEPARTMENT CHIEFS

Each Department Chief shall:

A. be an Active Staff member;

B. be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

C. satisfy the eligibility criteria in Section 7.1-2.

8.6 APPOINTMENT AND REMOVAL OF DEPARTMENT CHIEFS

8.6-1 Except as otherwise provided by contract, Department Chiefs shall be elected by the department, subject to Board confirmation. The election shall be by ballot. Ballots may be returned in person, by mail, by electronic mail or by facsimile. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.

8.6-2 Any Department Chief may be removed by a two-thirds vote of the department members; or by a two-thirds vote of the Medical Executive Committee subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

A. failure to comply with applicable policies, Bylaws, or Rules and Regulations;

B. failure to perform the duties of the position held;

C. conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

D. an infirmity that renders the individual incapable of fulfilling the duties of that office.

8.6-3 Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least ten days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department or Medical Executive Committee or the Board, as applicable, prior to a vote on such removal.

8.6-4 Department Chiefs shall serve a term of at least one year.

8.7 DUTIES OF DEPARTMENT CHIEFS

8.7-1 Each Department Chief is accountable for the following:

A. all clinically related activities of the department;

B. all administratively related activities of the department, unless otherwise provided for by the Hospital;

C. continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

D. recommending criteria for clinical privileges that are relevant to the care provided in the department;

E. evaluating requests for clinical privileges for each member of the department;

F. assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

G. the integration of the department into the primary functions of the Hospital;

H. the coordination and integration of interdepartmental and intradepartmental services;

I. the development and implementation of policies and procedures that guide and support the provision of services;

J. recommendations for a sufficient number of qualified and competent persons to provide care or services;

K. determination of the qualifications and competence of department personnel who provide patient care services;

L. continuous assessment and improvement of the quality of care and services provided;

M. maintenance of quality monitoring programs, as appropriate;

N. the orientation and continuing education of all persons in the department;

O. recommendations for space and other resources needed by the department;

P. performing all functions authorized in the Credentials Policy including collegial intervention; and

Q. appointing one or more member(s) of the active staff in good standing in the department as Vice Chiefs as deemed necessary, subject to approval of the Medical Executive Committee.

8.8 SECTIONS

8.8-1 Functions of Sections:

A. Sections may perform any of the following activities:

1. continuing education;

2. discussion of policy;

3. discussion of equipment needs;

4. development of recommendations to the Department Chief or the Medical Executive Committee;

5. participation in the development of criteria for clinical privileges (when requested by the Department Chief); and

6. discussion of a specific issue at the special request of a Department Chief or the Medical Executive Committee.

B. No minutes or reports will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, Department Chief, Credentials Committee, or Medical Executive Committee.

C. Sections shall not be required to hold any number of regularly scheduled meetings.

8.8-2 Qualifications and Appointment of Section Chiefs: Section Chiefs shall meet the same qualifications, and shall be subject to the same appointment and removal provisions as Department Chiefs except they are not required to satisfy the qualification of a minimum of a three-year Active Staff appointment.

8.8-3 Duties of Section Chiefs: The section chief shall carry out the duties requested by the Department Chief. These duties may include:

A. review and reporting on applications for initial appointment and clinical privileges, including interviewing applicants;

B. review and reporting on applications for reappointment and renewal of clinical privileges;

C. evaluation of individuals during the provisional period;

D. participation in the development of criteria for clinical privileges;

E. review and reporting on the professional performance of individuals practicing within the section; and

F. if the Section Chief has a conflict of interest with the individual under review, then delegation of such duties back to the Department Chief of the review of applications for appointment, reappointment, or clinical privileges or questions that may arise is appropriate.

ARTICLE 9:
COMMITTEES

9.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the Medical Staff as may from time to time be necessary and desirable to perform the functions of the Medical Staff required by these Bylaws or necessarily incidental thereto. All Medical Staff Members to serve on committees and Committee Chairpersons shall be appointed by the Chief of Staff of the Medical Staff and are appointed for the medical staff year, except as otherwise extended or provided in these Bylaws. All Hospital personnel, other than Medical Staff Members, to serve on committees shall be appointed by the CAO of the Hospital. The Chief of Staff of the Medical Staff shall appoint Medical Staff Members to Hospital-wide committees if requested by the CAO of the Hospital. Committees of the Hospital that choose to meet together may do so, unless otherwise specifically required by these Bylaws.

All committees shall:

1. Maintain a record of attendance at their meetings;

2. Maintain a record of their procedures; and

3. Submit timely reports of their activities and copies of the minutes of their meetings to the Medical Executive Committee.

9.2 MEDICAL EXECUTIVE COMMITTEE

9.2-1 Composition:

A. The Medical Executive Committee shall include at a minimum the officers of the Medical Staff, Chiefs of the Departments, the Chairperson of the Credentials Committee, the Chairperson of the Peer Review Committee, Section Chiefs as applicable, and may include up to three at-large active staff member representatives elected by and from the active members of the Medical Staff who do not have representation by a Section. In addition to these physician members of the Medical Executive Committee, the Medical Executive Committee may appoint up to a maximum of two additional members who are Advanced Practice Providers each from a different department, that have been granted clinical privileges or a scope of practice at the Hospital, provided that a majority of the total composition of the Medical Executive Committee is physicians actively practicing at the Hospital.

B. The Chief of Staff will chair the Medical Executive Committee.

C. The CAO, the Vice President of Medical Affairs, shall be ex officio members of the Medical Executive Committee, without vote.

9.2-2 Duties:

The Medical Executive Committee has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff Members with clinical privileges. This authority may be removed by amending these Bylaws. The Medical Executive Committee is responsible for the following:

A. acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

B. recommending directly to the Board on at least the following:

1. the Medical Staffs structure;

2. the mechanism used to review credentials and to delineate individual clinical privileges;

3. applicants for Medical Staff appointment;

4. delineation of clinical privileges for each eligible applicant;

5. participation of the Medical Staff in Hospital performance improvement activities;

6. the mechanism by which Medical Staff appointment may be terminated;

7. hearing procedures;

8. the sources of clinical patient care services to be provided through contracts;

9. reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

10. quality indicators to promote consistency regarding patient care services;

11. activities related to patient safety;

12. the process of analyzing and improving patient satisfaction;

13. continuing medical education activities; and

14. reviewing (through delegation to the Bylaws Committee), at least every two years, the Bylaws, Policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable.

C. informing the Medical Staff of the accreditation program and the accreditation status of the Hospital;

D. oversee that portion of the corporate compliance plan pertaining to the Medical Staff;

E. hold medical staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities;

F. take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of the medical staff members including collegial and educational efforts and investigations, when warranted;

G. periodically approve the qualifications of the radiology staff who use equipment and administer procedures, and approve the specifications for the qualifications, training, functions and responsibilities of the nuclear medicine staff; and

H. performing such other functions as are assigned to it by these Bylaws, by the Board, or by other applicable policies.

9.2-3 Meetings:

The Medical Executive Committee shall meet at least monthly, or more often as necessary to fulfill its responsibilities, and shall maintain a permanent record of its proceedings and actions. The Medical Executive Committee has the right to make a motion for Executive Session in accordance with the exceptions set forth in the State Open Hospital Proceedings statute, found in W. Va. Code. If there is a majority affirmative vote to accept the motion for executive session, the Regular Session will recess. When the Medical Executive Committee meets in Executive Session, only the members of the Committee and those who they request to remain, may be present for the discussion. There are no notes taken during executive session. The process to recess General Session and move to Executive Session will be as follows:

> "I move that General Session be recessed in order to conduct business in accordance with exceptions set forth in State Open Hospital Proceedings statute, found in W. Va. Code."

When executive business is completed, a motion will be made to return to the Public Session.

9.3 JOINT CONFERENCE COMMITTEE

9.3-1 Composition:

There shall be a Joint Conference Committee, as an as needed committee, of the Medical Staff and the Board of Directors, composed of four (4) members of the Medical Executive Committee (these members shall be the Chief of Staff the Medical Staff, the Vice Chief of Staff of the Medical Staff, the Secretary/Treasurer of the Medical Staff, and one (1) other Medical Executive Committee member appointed by the Chief of Staff of the Medical Staff); and four (4) members of the Board of Directors appointed by the Chairperson of the Board of Directors. The

Chairperson of the committee shall be either the Chairperson or Vice-Chairperson of the Board of Directors or the Chief or Vice-Chief of Staff of the Medical Staff. The committee may meet when and as needed. A meeting may be called by the Chairperson of the Board of Directors when requested by either the Board of Directors or the Chief of Staff.

The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital and Medical Staff policy, practice and planning, provide a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred to it by the Medical Executive Committee or by the Board of Directors, and fulfill responsibilities assigned to it by the Bylaws of the Medical Staff and of the Hospitals.

9.3-2 Duties:

The functions of the Joint Conference Committee are to:

A. Review broad health or health related issues presented by the Board of Directors, Administration, or Medical Staff, to determine relevance to Hospital policy development or policy change; and

B. Hear and act upon internal disputes between Administration or professional staff and the Medical Staff, or between departments of the Medical Staff, which if not resolved will harm the image, efficiency or effectiveness of the delivery of health services by the Hospital.

C. The Joint Conference Committee serves as a forum for discussion of potential issues of disagreement or concern regarding any aspects of Hospital and medical staff policy, practice and planning which may be resolved through discussion and interaction, and for interaction between the Board of Directors and the Medical Staff on such matters as may be referred to it by the Board or by the Medical Executive Committee.

D. The Joint Conference Committee will assist in resolving disputes where the Board of Directors decides to take action inconsistent with the Medical Executive Committee's recommendations.

9.4 ADDITIONAL MEDICAL STAFF FUNCTIONS

The Medical Executive Committee shall organize Medical Staff committees to perform the following functions or shall assign these functions to departments, sections, or interdisciplinary Hospital committees:

9.4-1 Credentialing

A. reviewing and evaluating the qualifications of each applicant for initial appointment, reappointment, modification of appointment, clinical privileges, or scope of practice;

B. reviewing and evaluating the recommendations of the appropriate department and, as applicable, Section Chiefs for each applicant for initial appointment, reappointment, modification of appointment, clinical privileges, or scope of practice;

C. submitting a report to the Medical Executive Committee regarding the qualifications of each applicant for initial appointment, reappointment, modification of appointment, clinical privileges, or scope of practice;

D. investigating, reviewing, and reporting on any matter related to the credentials of a Medical Staff Member, Advanced Practice Provider, or other individual exercising clinical privileges or a scope of practice, whenever such matter is referred by the Chief of Staff, Medical Executive Committee, or other individual or committee charged with addressing matters related to practitioner qualifications; and

E. submitting monthly reports to the Medical Executive Committee regarding the status of pending applications, including the reasons for any inordinate delay in processing a complete application or request.

9.4-2 Utilization Review

A. preparing a utilization review plan that is appropriate to the Hospital and meets the requirements of law. The plan must provide for the review of admissions and continued Hospital stays, discharge planning, and data collection and reporting;

B. educating the Medical Staff regarding the utilization review plan;

C. monitoring compliance with the utilization review plan; and

D. conducting studies, taking action, submitting reports, and making recommendations as required by the utilization review plan.

9.4-3 Medical Records

A. reviewing and evaluating medical records to determine that they (1) properly describe the condition and progress of the patient, the treatment provided, the results of treatment, and the identification of responsibility for all actions taken; (2) are sufficiently complete per policy so as to facilitate continuity of care in the Hospital; (3) meet the standards of patient care usefulness and of historical validity required by the staff; and (4) are adequate, in form and content, to permit patient care audit and other quality maintenance activities to be performed;

B. reviewing and recommending necessary amendments to Medical Staff and Hospital policies and Rules and Regulations relating to medical records, including medical record completion, forms, formats, filing, indexing, storage, destruction, and availability;

C. recommending methods to enforce policies and Rules and Regulations relating to medical records;

D. providing a liaison between the Medical Staff and the administration and medical record professionals on matters relating to medical record practices; and

E. maintaining a record of all actions taken and submitting periodic reports and recommendations to the Medical Executive Committee concerning medical record practices.

9.4-4 Pharmacy and Therapeutics

A. assisting in development of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital;

B. advising the Medical Staff and the Hospital's Pharmacy Services Department on matters pertaining to the choice of available drugs;

C. recommending drugs to be stocked on the nursing units and by other services;

D. developing and periodically reviewing a formulary or drug list for use in the Hospital;

E. evaluating clinical data concerning new drugs or preparations requested for use in the Hospital, including ambulatory settings;

F. establishing policies concerning the use and control of investigational drugs and of research in the use of recognized drugs;

G. making recommendations to the Medical Executive Committee concerning the documentation of administration of all drugs, including kinetics, on patient medical records; and

H. maintaining a record of all activities and submitting periodic reports and recommendations to the Medical Executive Committee concerning drug utilization policies.

9.4-5 Infection Control

A. maintaining surveillance over the Hospital infection control program;

B. developing a system for reporting, identifying, and analyzing the incidence and cause of all infections;

C. developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation and sanitation techniques;

D. developing, evaluating, and revising policies and procedures for infection control relating to all phases of the Hospital's activities including: operating rooms, delivery

rooms, special care units, central supply, housekeeping 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, and food sanitation and waste management;

E. coordinating action on findings from the Medical Staffs review of the clinical use of antibiotics; and

F. acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, the departments, the sections, and other Medical Staff and Hospital committees.

9.4-6 Safety, Sanitation, and Disaster Planning

A. developing and periodically reviewing, in cooperation with Hospital Administration, a written plan designed to safeguard patients at the time of an internal disaster and requiring that all personnel rehearse fire and other types of disaster drills on each shift, as often as shall be required by the Joint Commission or applicable laws and regulations; and

B. developing and periodically reviewing, in cooperation with Hospital Administration, a written plan for the care, reception, and evacuation of mass casualties, and assuring that such plan is coordinated with the inpatient and outpatient services of the Hospital, adequately relates to other available resources in the community and coordinates the Hospital's role with other agencies in the event of disasters in the Hospital's community and other nearby communities, and is rehearsed by all personnel involved as often as shall be required by the Joint Commission or applicable laws and regulations.

9.4-7 Nominating

A. consulting with members of the staff concerning the qualifications and acceptability of prospective nominees for election as Medical Staff officers, at-large members of the Medical Executive Committee, or any other Medical Staff leadership position elected by the Staff; and

B. submitting one or more nominations for each elective office of the staff to be filled, whether through expiration of the prior term, vacancy in the office, or otherwise.

9.5 PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

A. patient safety, including mortality review and processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

B. the Hospital's and individual practitioners' performance on Joint Commission or accrediting designated body, and Centers for Medicare & Medicaid Services ("CMS") core measures;

C. medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

D. the utilization of blood and blood components, including review of significant transfusion reactions;

E. operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

F. education of patients and families;

G. coordination of care, treatment and services with other practitioners and Hospital personnel;

H. accurate, timely and completion of medical records;

I. the use of developed criteria for autopsies;

J. sentinel events, including root cause analyses and responses to unanticipated adverse events;

K. nosocomial infections and the potential for infection;

L. unnecessary procedures or treatment; and

M. appropriate resource utilization.

9.6 APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS

All Committee Chairpersons and members shall be appointed by the Chief of Staff, in consultation with the Medical Executive Committee. Committee Chairpersons shall be selected based on the criteria set forth in Section 7.1-2 of these Bylaws. The Chief of Staff and the CAO (or their respective designees) shall be members, ex officio, without vote, on all committees, unless otherwise stated.

9.7 CREATION OF STANDING COMMITTEES

The Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more Medical Staff functions. In the same manner, except for the Medical Executive Committee and the Joint Conference Committee, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an

individual, a standing committee, or a special task force shall be performed by the Medical Executive Committee.

9.8 SPECIAL TASK FORCES

Special task forces shall be created and their members and Chairpersons shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 10:
MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 Regular Meetings: The Medical Staff shall meet at least quarterly.

10.1-2 Special Meetings: Special meetings of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, the Board, or by a petition signed by not less than twenty-five percent of the Active Staff.

10.2 DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 Regular Meetings: Except as otherwise provided in these Bylaws, each department and committee shall meet regularly, at times set by the presiding officer.

10.2-2 Special Meetings: A special meeting of a department or committee may be called by or at the request of the presiding officer, the Chief of Staff, or by a petition signed by not less than one-fourth of the Active Staff members of that department, section, or the members of that committee, but not by fewer than two members.

10.3 PROVISIONS COMMON TO ALL MEETINGS

10.3-1 Notice of Meetings:

A. Medical Staff Members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, sections, and committees at least one week in advance of the meetings. Notice may also be provided by electronic posting or notification at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.

B. When a special meeting of the Medical Staff, a department and/or a committee is called, all of the provisions in Paragraph A shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Electronic posting may not be the sole mechanism used for providing notice.

C. The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

10.3-2 Quorum and Voting:

A. For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members present shall constitute a quorum.

B. Recommendations and actions of the Medical Staff, departments, sections, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present and entitled to vote.

C. The voting members of the Medical Staff, a Department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Chairperson by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the Chairperson by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

D. Meetings may be conducted by telephone conference provided that all persons participating in the meeting can hear each other.

10.3-3 Agenda: The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, section, or committee.

10.3-4 Rules of Order:

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff department, or committee custom shall prevail at all meetings, and the Department Chief or Committee Chairperson shall have the authority to rule definitively on all matters of procedure.

10.3-5 Minutes, Reports, and Recommendations:

A. Minutes of all meetings of the Medical Staff, departments, and committees (and applicable section meetings) shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

B. A summary of all recommendations and actions of the Medical Staff, departments, sections, and committees shall be transmitted to the Medical Executive Committee, CAO, and Vice President of Medical Affairs. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees.

C. A permanent file of the minutes of all meetings shall be maintained by the Hospital.

10.3-6 Attendance Requirements:

A. Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable department, section, and committee meetings each year as per policy, Rules and Regulations.

ARTICLE 11:
PEER REVIEW AND CORRECTIVE ACTION

11.1 ROUTINE CORRECTIVE ACTION

11.1-1 Collegial Intervention

A. The Hospital encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an Advanced Practice Provider or Medical Staff Member's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Medical Staff Member to resolve questions that have been raised.

B. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

C. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

1. advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2. proctoring, monitoring, consultation, and letters of guidance; and

3. sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist Medical Staff Members to conform their practices to appropriate norms.

D. The relevant Medical Staff leader(s) will include documentation of collegial intervention efforts in a Medical Staff Member's confidential file. The Medical Staff Member or Advanced Practice Provider will have an opportunity to review it and respond in writing. The response will be maintained in that Medical Staff Member's file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management.

F. The relevant Medical Staff leader(s), in conjunction with the CAO, will determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). Medical Staff leaders may also direct these matters to the Medical Executive Committee for further action.

11.2 INVESTIGATIONS

11.2-1 Criteria for Initiation of Corrective Action

A. Whenever the professional conduct and activities of any Medical Staff Member or any Advanced Practice Provider raise serious concerns of noncompliance with these Bylaws, Medical Staff Rules and Regulations, or other Hospital policies, corrective action against such Medical Staff Member or Advanced Practice Provider may be initiated by any officer of the Medical Staff, by the Chief of any Department or standing committee of the Medical Staff, by the CAO of the Hospital, or by the Board of Directors. All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific conduct or activities which constitute the grounds for the request. The Chief of Staff of the Medical Staff shall promptly notify the CAO of the Hospital in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the CAO of the Hospital fully informed of all action taken in connection therewith.

B. Causes for corrective action may include but are not limited to concerns related to:

1. the clinical competence or clinical practice of any member of the Medical Staff or Advanced Practice Provider, including the care, treatment, or management of a patient or patients;

2. the known or suspected violation by any member of the Medical Staff or Advanced Practice Provider of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff;

3. observed physical or mental impairment that may reasonably interfere with the Medical Staff Member's or Advanced Practice Provider's ability to fulfill his or her duties under the Bylaws, policies, or the Rules and Regulations of the Hospital or the Medical Staff;

4. conduct reasonably probable of being damaging to the reputation of the Medical Staff, the Hospital or the medical profession in general;

5. conduct that could reasonably be construed as constitute fraud, abuse, or unlawful;

6. conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others, e.g., violence against another, disruptive behavior, driving under the influence of a mind-altering substance; and/or

7. conduct that calls into question the qualifications of the individual for membership or clinical privileges, or is in anyway detrimental to a patient's safety or to the delivery of quality patient care.

C. The person to whom the matter is referred will make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, will forward it in writing to the Medical Executive Committee.

D. No action taken pursuant to this Section will itself constitute an investigation. The initiation of a corrective action procedure under this Section 7.2-1 shall not preclude nor require the initiation of a precautionary suspension of the relevant Medical Staff Member under Section 7.3-1 of these Bylaws.

11.2-2 Initiation of Investigation

A. When a question involving clinical competence or professional conduct is referred to, or raised by the Medical Executive Committee, the Medical Executive Committee will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the code of conduct policy or the physician practitioner health policy), to reject the need for further review or to proceed in another manner including collegial intervention. In making this determination, the Medical Executive Committee may discuss the matter with the Medical Staff Member or Advanced Practice Provider. An investigation will begin only after a formal determination by the Medical Executive Committee to do so.

B. The Medical Executive Committee will inform the Medical Staff Member or Advanced Practice Provider that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the Medical Staff Member immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

C. The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

D. The Chief of Staff will keep the CAO fully informed of all action taken in connection with an investigation.

11.2-3 Investigative Procedure

A. Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee will not include partners, associates, or relatives of the Medical Staff Member or Advanced Practice Provider being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the Medical Staff Member or Advanced Practice Provider under

review, the ad hoc committee will include a peer of the Medical Staff Member or Advanced Practice Provider when possible (e.g., physician, dentist, oral surgeon or podiatrist).

B. The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

1. the clinical expertise needed to conduct the review is not available on the Medical Staff; or

2. the Medical Staff Member or Advanced Practice Provider under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

3. the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

C. The investigating committee may require the Medical Staff Member or Advanced Practice Provider to procure an impartial physical and/or mental examination of the Medical Staff Member or Advanced Practice Provider by health care professional(s) acceptable to the investigating committee. The Medical Staff Member or Advanced Practice Provider being investigated will execute a release allowing (1) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (2) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. If the Medical Staff Member or Advanced Practice Provider being investigated refuses to have such an evaluation the investigating committee may conclude that the result of such evaluation would have been adverse and unfavorable to the Medical Staff Member or Advanced Practice Provider.

D. The Medical Staff Member or Advanced Practice Provider may have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the Medical Staff Member or Advanced Practice Provider will be informed of the general questions being investigated. At the meeting, the Medical Staff Member or Advanced Practice Provider will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The Medical Staff Member or Advanced Practice Provider being investigated will not have the right to be represented by legal counsel at this meeting.

E. The investigating committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the

investigation and issue its report within thirty (30) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for a Medical Staff Member or Advanced Practice Provider to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it will inform the Medical Staff Member or Advanced Practice Provider of the reasons for the delay and the approximate date on which it expects to complete the investigation.

F. At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations and submit them to the Medical Executive Committee.

11.2-4 Medical Executive Committee Action

A. Within thirty (30) days following receipt of the report of the investigating committee, the Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:

1. determine that no action is justified;

2. issue a letter of guidance, counsel, warning, or reprimand;

3. impose conditions for continued appointment;

4. impose a requirement for proctoring, monitoring or consultation;

5. recommend additional training or education;

6. recommend reduction of clinical privileges;

7. recommend suspension of clinical privileges for a term;

8. recommend revocation of appointment and/or clinical privileges; or

9. make any other recommendation that it deems necessary or appropriate.

B. A recommendation by the Medical Executive Committee that would entitle the Medical Staff Member to request a hearing pursuant to Article 13 will be forwarded to the CAO, who will promptly inform the Medical Staff Member by Special Notice. The CAO will hold the recommendation until after the Medical Staff Member has exercised or waived the procedural rights to a hearing and appeal provided in Article 13.

C. If the Medical Executive Committee makes a recommendation regarding an Advanced Practice Provider, or a Medical Staff Member that does not entitle the Medical

Staff Member to request a hearing in accordance with Articles 12 and 13, it will take effect immediately without action of the Board and without the right to request a hearing or appeal to the Board in accordance with Article 13 and will remain in effect unless modified by the Board. A report of the action taken and reasons therefore is provided to the CAO who will provide the report to the Board.

D. In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the Medical Staff Member to request a hearing in accordance with Articles 12 and 13, the CAO will inform the Medical Staff Member by Special Notice. No final action will occur until the Medical Staff Member has exercised or waived the procedural rights to a hearing and appeal provided in Articles 8 and 16.

E. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

11.2-5 Joint Conference Committee and Board Option

When the Medical Executive Committee, after consideration of a request for corrective action, or after review of a report of an investigation, determines that no corrective action be taken, the CAO shall report such determination to the Joint Conference Committee and the Board of Directors. The Board of Directors, in its discretion, may appoint a committee to conduct an investigation of the conduct that served as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in Section 7.2-4. All Board appointees to the committee shall be free of any conflict of interest in the matter and persons involved in the matter.

Appointment of a committee by the Board of Directors as described above may occur only after the Board of Directors has notified the Medical Executive Committee of its intention to do so and sought comment from the Joint Conference Committee (as defined below) as to the need for such action.

11.2-6 Procedural Rights

Any action by the Medical Executive Committee pursuant to Sections 11.2-4A 3, 4 (if such action requires approval by the proctor or consultant in advance), 6, 7, and 8, or any combination of such actions, or action by the Board of Directors pursuant to Section 11.2-5, shall entitle the Medical Staff Member to the procedural rights as provided in Article 12, and the matter shall be processed in accordance with the provisions of Article 13.

11.2-7 Initiation of corrective action pursuant to Sections 11.1 or 11.2 does not preclude imposition of a summary precautionary suspension as provided for in Section 11.3, nor does it require the prior imposition of such a suspension.

11.3 PRECAUTIONARY SUSPENSION

11.3-1 Grounds for Precautionary Suspension or Restriction

A. Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, any two of the following, the Chief of Staff, the Chief of a clinical department, Vice President of Medical Affairs, the CAO, the Board Chairperson, or the Medical Executive Committee will have the authority to (1) afford the Medical Staff Member or Advanced Practice Provider an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of a Medical Staff Member's or Advanced Practice Provider's clinical privileges.

B. A precautionary suspension or restriction can be imposed at any time including, but not limited to, whenever a Medical Staff Member or Advanced Practice Provider willfully disregards or overtly violates these Bylaws, Medical Staff Rules and Regulations, Policies, or whenever his/her conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of serious injury or damage to the health or safety of any patient, employee or other person present in the Hospital, whenever the conduct of the Medical Staff Member materially disrupts the operations of any department or unit of the Hospital, or following any recommendation of the Medical Executive Committee that would entitle the Medical Staff Member to request a hearing.

C. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

D. A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the CAO and the Chief of Staff, and will remain in effect unless it is modified by the CAO or Medical Executive Committee.

E. The Medical Staff Member or Advanced Practice Provider in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

11.3-2 Medical Executive Committee Procedure

A. As soon as possible after such precautionary suspension, if the precautionary suspension was not imposed by the Medical Executive Committee, it will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the Medical Staff Member or Advanced Practice Provider may be given an opportunity to meet with the Medical Executive Committee. The Medical Staff Member or Advanced Practice Provider may propose ways other than precautionary suspension or restriction to protect

patients, employees, and/or the smooth operation of the Hospital, depending on the circumstances.

B. After considering the matters resulting in the suspension or restriction and the Medical Staff Member's or Advanced Practice Provider's response, if any, the Medical Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable). The action of the Medical Executive Committee shall be considered a professional review action

C. Unless the Medical Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Medical Staff Member shall be entitled to the procedural rights as provided in Article 12, and the matter shall be processed in accordance with the provisions of Article 13. Other than a decision by the Medical Executive Committee to terminate the suspension, the terms of the precautionary suspension as sustained by the Medical Executive Committee shall remain in effect pending a final decision by the Board of Directors. If the Medical Executive Committee recommends the termination of the suspension, the suspension will be lifted upon such action, provided, however, the Board of Directors shall have the right to reverse the action.

If the Board of Directors, after such review, decides to continue the suspension, or the Board of Directors takes no action to terminate the suspension within thirty (30) days after it was imposed, and the suspension was not otherwise terminated by the Medical Executive Committee prior to such thirty (30) day period, the Medical Staff Member shall be entitled to the procedural rights as provided in Article 12, and the matter shall be processed in accordance with the provisions of Article 13.

If the Medical Executive Committee recommends less restrictive terms of suspension, the less restrictive terms will become effective upon action taken by the Medical Executive Committee. If the Board of Directors, after review, decides to continue the suspension, either original or as modified, or if the Board of Directors takes no action to terminate the suspension within thirty (30) days after it was imposed, the Medical Staff Member shall be entitled to the procedural rights as provided in Article 12, and the matter shall be processed in accordance with the provisions of Article 13.

11.3-3 Care of Patients

A. Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff will assign to another Medical Staff Member or Advanced Practice Provider with appropriate clinical privileges responsibility for care of the suspended Medical Staff Member's or Advanced Practice Provider's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician.

B. All members of the Medical Staff and Advanced Practice Providers have a duty to cooperate with the Chief of Staff, the Department Chief, the Medical Executive Committee, and the CAO in enforcing precautionary suspensions or restrictions.

11.4 AUTOMATIC SUSPENSION AND REVOCATION

11.4-1 Failure to Complete Medical Records or Violation of Hospital Policy:

Failure to complete medical records or violation of any other Hospital policy, will result in automatic relinquishment of all clinical privileges, after notification of delinquency by the appropriate department such as the Medical Staff Office or medical records department. Relinquishment will continue until all delinquent records are completed or the violation has been cured and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations will result in automatic resignation from the Medical Staff.

11.4-2 Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

A. Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below or failure to satisfy any of the threshold eligibility criteria set forth in these Bylaws must be promptly reported to the Medical Staff Office.

B. A Medical Staff Member’s or Advanced Practice Provider’s appointment and clinical privileges will be automatically relinquished if any of the following occur:

1. Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on a Medical Staff Member's or Advanced Practice Provider’s license. Any subsequent request for the opportunity to practice at the Hospital after the individual has regained his or her license shall only be by application for appointment to the Medical Staff in accordance with Section 5.4-1.

2. Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on a Medical Staff Member’s or Advanced Practice Provider’s DEA controlled substance authorization. Any subsequent request for the opportunity to practice at the Hospital after the Practitioner has regained his or her DEA registration shall only be by application for appointment to the Medical Staff in accordance with Section 5.4-1.

3. Insurance Coverage: Failure, due to lapse, termination, or any other reason, to maintain current, valid professional liability coverage as required under these Bylaws. Once the required amount of professional liability insurance has been obtained, the Medical Executive Committee shall review the circumstances relating to the lapse in coverage and determine whether to recommend that the Staff member's privileges be restored or to treat the matter as a request for corrective action under Section 11.2.

4. Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs. Automatic revocation under this paragraph shall continue for so long as the government's exclusion or suspension is in effect, without recourse to the hearing and appellate review and procedural rights set forth in Article 13.

5. Criminal Activity: Conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse. Any subsequent request for the opportunity to practice at the Hospital after such matter has been concluded shall only be by application for appointment to the Medical Staff in accordance with Section 5.4-1; provided, however, that any Medical Staff Member or Advanced Practice Provider who is convicted of a felony shall not be eligible for appointment or reappointment to the Staff.

C. An Advanced Practice Provider's clinical privileges will be automatically relinquished if the Advanced Practice Provider fails to satisfy any of the other threshold eligibility criteria set forth in these Bylaws.

D. A Medical Staff Member's appointment and clinical privileges will be automatically relinquished, without entitlement to the procedural rights outlined in these Bylaws, if the Medical Staff Member fails to satisfy any of the other threshold eligibility criteria set forth in these Bylaws.

E. Automatic relinquishment will take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If a Medical Staff Member or Advanced Practice Provider engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment will be deemed permanent.

F. Failure to resolve the underlying matter leading to a Medical Staff Member's clinical privileges being automatically relinquished in accordance with paragraphs B1, B2 or B3 above, within 90 days of the date of relinquishment will result in automatic resignation from the Medical Staff.

G. Requests for reinstatement will be reviewed by the relevant Department Chief, the Chairperson of the Credentials Committee, the Chief of Staff, Vice President of Medical Affairs, and the CAO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff Member or Advanced Practice Provider may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the Credentials Committee, Medical Executive Committee, and Board for review and recommendation.

11.4-3 Failure to Provide Requested Information:

Failure to provide information pertaining to an Advanced Practice Provider's qualifications for clinical privileges, in response to a written request from the Credentials

Committee, the Medical Executive Committee, the CAO, or any other committee authorized to request such information, will result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

Failure to provide information pertaining to a Medical Staff Member's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the CAO, or any other committee authorized to request such information, will result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

11.4-4 Failure to Attend Special Conference:

A. Whenever there is a concern regarding clinical practice or professional conduct involving any Medical Staff Member or Advanced Practice Provider, the Department Chief or the Chief of Staff may require the Medical Staff Member or Advanced Practice Provider to attend a special conference with Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

B. The notice to the Medical Staff Member or Advanced Practice Provider regarding this conference will be given by Special Notice at least three days prior to the conference and will inform the Medical Staff Member that attendance at the conference is mandatory.

C. Failure of the Medical Staff Member or Advanced Practice Provider to attend the conference will be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure will result in automatic relinquishment of all or such portion of the Medical Staff Member's or Advanced Practice Provider's clinical privileges as the Medical Executive Committee may direct. Such relinquishment will remain in effect until the matter is resolved.

D. The Committee or body which requested the Medical Staff Member's or Advanced Practice Provider's appearance shall recommend the conditions, if any, under which the Medical Staff Members' or Advanced Practice Provider privileges may be restored.

ARTICLE 12:
HEARINGS AND APPELLATE REVIEW

12.1 HEARINGS AND APPELLATE REVIEW

12.1-1 Adverse Medical Executive Committee Recommendation

When any Medical Staff Member receives Special Notice of an adverse recommendation or action of the Medical Executive Committee, as described in Section 13.1-1 and Section 13.1-2, he/she shall be entitled, upon request, to a hearing. If the determination of the Board of Directors after review of the Medical Executive Committee recommendation is adverse to the

Medical Staff Member, he/she shall then be entitled, upon request, to an appellate review before a final decision is rendered.

12.1-2 Adverse Board Decision

When any Medical Staff Member receives Special Notice of an adverse decision by the Board of Directors taken under circumstances where the Medical Staff Member previously had no right to a hearing, such Medical Staff Member shall be entitled, upon request, to a hearing. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request, to an appellate review before a final decision is rendered.

12.1-3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in Article 13.

12.1-4 Exceptions

The denial, termination or reduction of temporary privileges, or any other actions, except those specified in Article 13, shall not give rise to any right to a hearing or appellate review.

12.2 REQUIRED REPORTS OF ADVERSE ACTIONS

When the Hospital has taken a professional review action as defined in the Health Care Quality Improvement Act (HCQIA) that is reportable pursuant to HCQIA, or is otherwise under a duty to report to a public agency or licensing board by other state or federal law, the report shall be submitted by the Medical Staff Support Service Personnel after review by the Chairperson of the Credentials Committee.

ARTICLE 13:
FAIR HEARING PLAN

13.1 INITIATION OF HEARING

13.1-1 Grounds for Hearing

An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

A. denial of initial appointment to the Medical Staff;

B. denial of reappointment to the Medical Staff;

C. revocation of appointment to the Medical Staff;

D. denial of requested clinical privileges;

E. revocation of clinical privileges;

F. suspension of clinical privileges for more than 30 days;

G. mandatory concurring consultation or proctoring requirement (i.e., the consultant or proctor must approve the course of treatment in advance); or

H. denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

No other recommendations will entitle the individual to a hearing. If the Board makes any of these recommendations without an adverse recommendation by the Medical Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the Medical Executive Committee" will be interpreted as a reference to "the Board."

13.1-2 Actions Not Grounds for Hearing

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

A. issuance of a letter of guidance, counsel, warning, or reprimand;

B. imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

C. termination of temporary privileges;

D. automatic relinquishment of appointment or privileges;

E. imposition of a requirement for additional training or continuing education;

F. precautionary suspensions for up to 30 days;

G. denial of a request for leave of absence or for an extension of a leave, other than for reasons of professional competence or conduct;

H. determination that an application is incomplete;

I. determination that an application will not be processed due to a misstatement or omission.

13.1-3 Notice of Recommendation

The CAO will promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

A. a statement of the recommendation and the general reasons for it;

B. a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this Special Notice; and

C. a copy of this Article.

13.1-4 Request for Hearing

An individual has thirty (30) days following receipt of the notice to request a hearing. The request shall be in writing to the CAO and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

13.1-5 Waiver by Failure to Request a Hearing

A practitioner who fails to request a hearing within the time and in the manner specified in Section 16.1-4 waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

A. An adverse action by the Board of Directors shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board of Directors.

B. An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board of Directors. The Board of Directors shall consider the Medical Executive Committee's recommendations at its next regular meeting following waiver. In its deliberations the Board of Directors shall review all the information and material considered by the Medical Executive Committee and may consider all other relevant information received from any source in making its final decision.

The CAO shall promptly send the practitioner Special Notice informing him/her of each action taken pursuant to this Section 16.1-5 and shall notify the Chief of Staff of the Medical Staff of each such action.

13.2 HEARING PREREQUISITES

13.2-1 Notice of Hearing and Statement of Reasons

A. Following the receipt of a request for a hearing, the CAO will schedule the hearing and provide, by Special Notice, the following:

1. the time, place, and date of the hearing;

2. a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

3. the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

4. a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

B. The hearing will begin as soon as practicable, but no sooner than 30 days after the Special Notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties or if a suspension is already in effect.

13.2-2 Witness List

A. At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

B. The witness list will include a brief summary of the anticipated testimony.

C. The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

13.2-3 Hearing Panel, Presiding Officer, and Hearing Officer

A. Hearing Panel

The CAO, after consulting with the Chief of Staff, will appoint a Hearing Panel in accordance with the following guidelines:

1. The Hearing Panel will consist of at least three members, one of whom will be designated as Chairperson.

2. The Hearing Panel may include any combination of:

(i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or

(ii) actively practicing physicians not connected with the Hospital (i.e., physicians not on the Medical Staff or not affiliated with the Hospital).

3. Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

4. Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

5. The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.

6. The Panel will not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.

7. The Panel will not include any individual who has either requested, or has served on a body that has recommended, the adverse action.

8. The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

B. Presiding Officer

1. The CAO may appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing.

2. If no Presiding Officer has been appointed, the Chair of the Hearing Panel will serve as the Presiding Officer and will be entitled to one vote.

3. The Presiding Officer will:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

(vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

4. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

5. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be an advisor to the Hearing Panel, but will not be entitled to vote on its recommendations.

C. Hearing Officer

1. As an alternative to a Hearing Panel, the CAO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

2. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

D. Objections

In the event the notice of hearing provided pursuant to Section 13.2-1 did not include the names of the members of the Hearing Panel, the Presiding Officer or the Hearing Officer, as the case may be, the CAO shall provide notice to the practitioner requesting the hearing promptly upon designation of such individuals. Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, will be made in writing, within ten days of receipt of notice, to the CAO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff will be given a reasonable opportunity to comment. The CAO will rule on the objection and give notice to the parties. The CAO may request that the Presiding Officer make a recommendation as to the validity of the objection.

13.2-4 Representation

Representation or assistance of either party by an attorney at law shall be permitted in accordance with Section 13.9-2.

13.3 PRE-HEARING PROCEDURES

13.3-1 General Procedures.

The pre-hearing and hearing processes will be conducted in a formal manner, but formal rules of evidence or procedure will not apply.

13.3-2 Provision of Relevant Information

A. Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing, and the individual along with his or her counsel, if any shall sign a confidentiality agreement. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate Agreements in connection with any patient Protected Health Information (PHI) contained in any documents provided.

B. Upon receipt of the above agreements and representations, the individual requesting the hearing will be provided with a copy of the following:

1. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense, provided, however, that all such records shall be treated confidentially and PHI shall be redacted to the extent possible;

2. reports of experts relied upon by the Medical Executive Committee;

3. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

4. copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

C. The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.

D. Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

E. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

F. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the

employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

13.3-3 Pre-Hearing Conference

The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses and may require that any exhibits or witnesses not provided and agreed upon in advance of the hearing may be excluded from the hearing. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross examination. It is expected that the hearing will last no more than 15 hours over a course of no more than three days, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

13.3-4 Stipulations

The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

13.4 HEARING PROCEDURE

13.4-1 Personal Presence Required

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 13.1-5.

13.4-2 Record of Hearing

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

13.4-3 Rights of Parties

A. At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

1. to call and examine witnesses, to the extent they are available and willing to testify;

2. to introduce exhibits;

3. to cross-examine any witness on any matter relevant to the issues;

4. to have representation by counsel who may be present but may not call, examine or cross-examine witnesses, or present the case unless otherwise agreed to by the parties;

5. to submit a written statement at the close of the hearing; and

6. to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

B. If the individual who requested the hearing does not testify, he or she may be called and questioned.

C. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

13.4-4 Procedure and Evidence

A. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if, in the judgment of the Hearing Officer or Presiding Officer (as the case may be), it is the sort of evidence upon which responsible persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

B. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The Hearing Panel may require one or both parties to prepare and submit to the Panel written statements of their position on the issues, prior to, during, or after, the hearing.

C. The Hearing Panel may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and exhibits.

D. The Hearing Officer or Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents.

13.4-5 Evidentiary Notice

In reaching a decision, the Hearing Panel may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or

scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of West Virginia. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Panel. The Panel shall also be entitled to consider any pertinent material contained on file in the Hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Staff and for clinical privileges.

13.4-6 Burden of Proof

The order of presentation and burden of proof for hearings conducted pursuant to this Section 16 shall be as follows:

A. For hearings instituted under Sections 13.1-1 A, B, C, D, or H, the individual requesting the hearing shall provide evidence in support of such individual's position. After such evidence is provided, the Credentials Committee or Medical Executive Committee shall provide evidence in support of its position.

B. For hearings instituted under Sections 13.1-1 E, F, or G, the Credentials Committee or Medical Executive Committee shall provide evidence in support of its recommendation. After such evidence has been provided, the individual requesting the hearing shall provide evidence in support of his or her position.

C. After evidence is provided under paragraphs A and B above, the Hearing Panel shall recommend against the individual requesting the hearing unless it determines that the individual has proven, by clear and convincing evidence, that the basis of the Credential Committee's or Medical Executive Committee's determination, or the conclusions drawn there from, were arbitrary, unreasonable, or capricious.

13.4-7 Post-Hearing Statement

Each party will have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

13.4-8 Postponement

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the CAO on a showing of good cause.

13.5 HEARING PANEL REPORT AND FURTHER ACTION

13.5-1 Basis of Hearing Panel Recommendation

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the

Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

13.5-2 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a concise statement of the basis for its recommendation.

13.5-3 Hearing Committee Report

A. Within fourteen (14) days after the conclusion of deliberations by the Hearing Panel, the Hearing Panel will deliver its report to the CAO. The CAO will send by Special Notice a copy of the report to the individual who requested the hearing. The CAO will also provide a copy of the report to the Medical Executive Committee.

B. The Medical Executive Committee, when its adverse recommendation or action occasioned the hearing, shall review the Hearing Panel report, and submit its comments on the Hearing Committee report to the Board of Directors.

13.6 APPELLATE REVIEW

13.6-1 Time for Appeal

A. Within ten (10) days after Special Notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the CAO either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

B. If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

13.6-2 Grounds for Appeal

The grounds for appeal will be limited to the following:

A. there was substantial failure by the Hearing Panel to comply with these Bylaws and/or the Bylaws of the Hospital or Medical Staff during the hearing, so as to deny a fair hearing; and/or

B. the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

13.6-3 Notice of Time and Place for Appellate Review

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board will schedule and arrange for an appeal. The individual will be given Special Notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved, but no later than ten days or longer than twenty-one days from the date of the request, unless otherwise agreed to by the parties. The time for the appellate review may be extended by the appellate review body for good cause.

13.7 APPELLATE REVIEW PROCEDURE

13.7-1 Nature of Proceedings

A. The Board may serve as the Review Panel or the Chairperson of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

B. Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

C. The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

13.7-2 Presiding Officer

The Chairperson of the Review Panel shall be the Presiding Officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum. He/she may be assisted by counsel.

13.7-3 Oral Statement

The Review Panel, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Review Panel.

13.7-4 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Review Panel, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

13.7-5 Powers

The Review Panel shall have all power granted to a hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

13.7-6 Recesses and Adjournment

The Review Panel may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Review Panel shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations the appellate review shall be declared finally adjourned.

13.7-7 Action Taken

The Review Panel may recommend the initial recommendation of the Hearing Panel be affirmed, modified or reversed.

13.7-8 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 13.7 have been completed or waived.

13.8 FINAL DECISION OF THE BOARD OF DIRECTORS

13.8-1 Final Decision of the Board

Within ten (10) days after the conclusion of the appellate review, the Board of Directors shall render its final decision in the matter, which shall be immediately effective and final. The CAO of the Hospital shall send notice of the Board of Directors' decision which includes a statement of the basis for the decision, to the practitioner by special notice, and to the Chief of Staff of the Medical Staff.

13.8-2 Right to One Hearing and One Appeal Only

No member of the Medical Staff will be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

13.9 GENERAL PROVISIONS

13.9-1 Hearing Officer Appointment and Duties

The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Chairperson of the Board of Directors after consultation with the Chief of Staff of the Medical Staff. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act in an impartial manner as the Presiding Officer of the hearing. If requested by the Hearing Committee, he/she may participate in its deliberations and act as its legal advisor, but he/she shall not be entitled to vote. The Hospital's attorney may not serve as hearing officer.

13.9-2 Attorneys

If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance, his/her request for such hearing or appellate review must so state. The practitioner shall include the name, address and telephone number of the attorney in his/her request. Failure to provide this information with the request shall permit the Hearing Committee or Appellate Review Committee to preclude participation by legal counsel. The Medical Executive Committee or the Board of Directors may also be allowed representation by an attorney upon providing notice to that effect to the practitioner at least ten (10) days prior to the scheduled hearing or appellate review. If the practitioner had not requested previously representation by legal counsel, the practitioner shall be informed that the other party plans to be represented by counsel by the CAO of the Hospital and be given the opportunity to be represented by counsel upon notice to the CAO of the Hospital as described above, at least seven (7) days prior to the hearing or appellate review. The foregoing shall not be deemed to limit the practitioner, the Medical Executive Committee or the Board of Directors in the use of legal counsel in connection with preparation for a hearing or an appellate review. When legal counsel attends and participates in proceedings, it is with the understanding they recognize the proceedings are not a judicial forum, but a forum for evaluation of a professional to render health services. Accordingly, the Hearing Panel and/or Review Panel retains the right to limit the role of legal counsel as participants in the proceedings.

13.9-3 Waiver

If at any time after receipt of Special Notice of an adverse recommendation, action or determination, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or determination, and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

13.9-4 Extensions

Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in Article 13 may be extended upon the agreement of the parties and, when necessary, by the Hearing Committee or Appellate Review Committee.

13.9-5 Release

By requesting a hearing or appellate review under the Fair Hearing Plan, a practitioner agrees to be bound by the provisions of Article 4 of the Medical Staff Bylaws in all matters relating thereto.

ARTICLE 14:
ADOPTION AND AMENDMENT OF BYLAWS

14.1 ADOPTION

These Bylaws shall be adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and all documents pertaining to the subject matter thereof. To the extent the Hospital Rules and Regulations, Policies, manuals, or Hospital policies are inconsistent, they shall be of no force and effect.

14.2 MEDICAL STAFF BYLAWS

14.2-1 Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the Medical Staff, or by the Bylaws Committee, or by the Medical Executive Committee. Proposed amendments to the Bylaws offered by a petition of the voting staff, as set forth above, will first be considered by the appropriate System-level Medical Staff Committee. Thereafter, the appropriate System-level Medical Staff Committee will report, either favorably or unfavorably, to each Medical Executive Committee at each Health System Hospital on such amendments. Each Medical Executive Committee of each Health System Hospital will make a recommendation back to the appropriate System-level Medical Staff Committee.

14.2-2 All proposed amendments must be reviewed and approved by the Medical Executive Committee and the appropriate System-level Medical Staff Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice of all approved proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

14.2-3 The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

14.2-4 The Medical Executive Committee may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the

Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 50% of the staff eligible to vote.

14.2-5 The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of the Bylaw reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression. However, all such changes must first be approved by the appropriate System-level Medical Staff Committee.

14.2-6 All amendments shall be effective only after approval by the Board.

14.2-7 If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Administrative Officer within two weeks after receipt of a request.

14.3 OTHER MEDICAL STAFF DOCUMENTS

14.3-1 In addition to the Medical Staff Bylaws, there shall be Policies, Procedures, and Rules and Regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice.

14.3-2 An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these two documents shall be provided to each voting member of the Medical Staff at least 10 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

14.3-3 The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 10 days from the date provided to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive committee, the provisional amendments shall

stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.

14.3-4 All other Policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee only after they have been approved by the appropriate System-level Medical Staff Committee. No prior notice is required.

14.3-5 Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by a majority of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents shall be provided to each voting member of the Medical Staff ten (10) days in advance of forwarding the proposed recommendation to the Medical Executive Committee. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

14.3-6 Adoption of and changes to the Advanced Practice Provider Policy, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

14.3-7 The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

14.4 CONFLICT MANAGEMENT PROCESS

14.4-1 When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

A. proposed amendments to the Medical Staff Rules and Regulations,

B. a new policy proposed by the Medical Executive Committee, or

C. proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

14.4-2 If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

14.4-3 This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

Nothing in this section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff Members to the Board will be directed through the CAO, who will forward the request for communication to the Chairperson of the Board. The CAO will also provide notification to the MEC by informing the Chief of Staff of all such exchanges. The Chairperson of the Board will determine the manner and method of the Board's response to the Medical Staff Member(s).