SOUTHEAST MISSOURI HOSPITAL MEDICAL STAFF BYLAWS

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Article I
CATEGORIES OF THE MEDICAL STAFF

1.01 Categories

The staff shall be divided into categories of active, associate, courtesy, consulting and honorary.

1.02 Active Staff

A. Qualifications. The active staff shall consist of physicians, dentists, and podiatrists each of whom:

(1) meets the basic qualifications as set forth in Section 6.03 of these Bylaws,

(2) regularly admits patients to, or is otherwise regularly involved in the care of patients in, the Hospital,

(3) has furnished the statements required by Section 6.06 (A) of these Bylaws and is no longer a provisional appointee, and

(4) has served the immediately preceding twelve months prior to his appointment to the active staff as an associate staff appointee.

B. Prerogatives. The prerogatives of an active staff appointee shall be to:

(1) admit patients to the Hospital as follows:

(a) all physician appointees except Emergency Department and Pathology Department physicians may admit without limitation.

(b) an oral surgeon may admit provided it is demonstrated, at the time of admission, that unless otherwise permitted by the credentials granted to him, a physician appointee of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient. A physician appointee of the Medical Staff shall assume responsibility for the care of any medical problem that may be present or may arise during hospitalization.

(c) a dentist or podiatrist may admit provided that a physician appointee of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during hospitalization. An appropriately privileged dentist or podiatrist is responsible for that part of his patient's History and Physical examination related to dentistry or podiatry, regardless of whether they have been granted comprehensive medical History and Physical privileges.

(2) exercise such clinical privileges as are granted to him.

(3) vote on all matters presented at general and special meetings of the Medical Staff and Hospital committees of which he is a member.

(4) hold office in the staff organization and in each department and committees of which he is an appointee or member.

C. Responsibilities. Each appointee of the active staff shall:

(1) discharge the basic responsibilities set forth in Section 6.04 of these Bylaws.

(2) retain responsibility within his area of professional competence for the daily care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision.

(3) actively participate in ongoing organizational performance improvement activities, the peer review process, supervision of provisional appointees, and in discharging such other staff functions as may from time to time be required.

(4) regularly attend meetings of the medical staff, medical staff departments, and medical staff committees in accordance with Article V, Section 5.02 (G) (1) of these Bylaws.

1.03 Associate Staff

A. Qualifications. The associate staff shall consist of physicians, dentists, and podiatrists, each of whom:

(1) is eligible for advancement to the active staff and will, in the ordinary course of events and unless he requests otherwise, be advanced to active staff status after serving twelve months on the associate staff.

(2) meets the qualifications specified in Section 6.03 of these Bylaws for appointment to the active staff.

B. Prerogatives. The prerogatives of an associate staff appointee shall be to:

(1) admit patients to the Hospital under the same conditions as specified for active staff appointees.

(2) exercise such clinical privileges as are granted to him.

Associate staff members shall not be eligible to vote or to hold office.

C. Responsibilities. Each appointee of the associate staff shall be required to discharge the same responsibilities as those specified for appointees of the active staff. Failure to fulfill those responsibilities shall be grounds for denial of advancement to active staff status.

1.04 Consulting Staff

A. Qualifications. The consulting staff shall consist of physicians, dentists and podiatrists, each of whom:

(1) meets the basic qualifications set forth in Section 6.03 of these Bylaws.

(2) is an appointee or a member of the active or associate staff of another hospital where he actively participates in a performance improvement program similar to that required of the staff of this Hospital.

(3) is a recognized specialist who does not regularly practice in this Hospital on a day-to-day basis.

(4) has had his services requested by one or more appointees of the active staff of this Hospital.

B. Prerogatives. The prerogatives of a consulting staff appointee shall be to:

(1) admit patients to the Hospital under the same conditions as specified for active staff appointees.

(2) exercise such clinical privileges as are granted to him.

(3) attend meetings of the staff and each department of which he is an appointee and any staff or Hospital education program.

Consulting staff appointees shall not be eligible to vote or to hold office.

C. Responsibilities. Each appointee of the consulting staff shall be required to discharge the basic responsibilities specified in Section 6.04 of these Bylaws, and further, shall retain responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision.

1.05 Courtesy Staff

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

(1) meets the basic qualifications set forth in Section 6.03 (A) of these Bylaws.

(2) desires to have an affiliation with the Hospital, but does not desire to have the privilege of routinely admitting or treating patients at the Hospital.

(3) currently is appointed to the Medical Staff, requests to transition to courtesy status, and receives approval by the Hospital Board of Directors.

B. Prerogatives. The prerogatives of a courtesy staff appointee shall be to attend meetings of the staff and each department to which they would normally be assigned, as well as any staff or Hospital education program. Courtesy staff members shall not be eligible to vote or to hold office. Dentists, podiatrists, and other consultative specialists as approved by the Hospital Board of Directors shall be allowed to see and treat patients upon the request of an active or associate staff appointee.

C. Responsibilities. An appointee of the courtesy staff is not required to attend staff or department meetings.

1.06 Honorary Staff

A. Qualifications. The honorary staff shall consist of physicians, dentists, and podiatrists recognized for their outstanding reputations or their previous long-standing service to the Hospital. Honorary staff appointees granted clinical privileges must meet the basic qualifications set forth for active appointees.

B. Prerogatives. Honorary staff appointees will not admit patients to the Hospital or exercise clinical privileges in the Hospital. However, the Medical Executive Committee may grant an exception to this rule. When such an exception is granted, the honorary staff appointee may admit patients to the Hospital within the limitations provided for active staff appointees and

may exercise such clinical privileges as are granted to him. Otherwise, the prerogatives of an honorary staff appointee shall be to attend staff and department meetings and any staff or Hospital education meeting. Honorary staff appointees shall not be eligible to vote or to hold office.

C. Responsibilities. Honorary staff who have been granted clinical privileges shall be required to discharge all the basic responsibilities specified in Section 6.04 of these Bylaws. Honorary staff who **do not** hold clinical privileges shall be required to discharge the responsibilities specified in Section 6.04 (C), (F) and (G) only.

1.07 Affiliate Physicians

Discussion of Affiliate, Non-Staff Physicians appears in Article VIII, Section 8.07 of these Bylaws.

1.08 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, dentist's, or podiatrist's staff appointment, by other articles in these Bylaws, or by other policies of the Hospital.

1.09 Waiver of Qualifications

Any qualifications may be waived at the discretion of the Board upon determination that such waiver will serve the best interests of the patients and of the Hospital.

Article II
STAFF DEPARTMENTS

2.01 Organization of Staff Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a chairman who is selected and has the authority, duties and responsibilities as specified in these Bylaws.

2.02 Designation

A. Current Departments. The current departments are set forth in the Organizational Manual, Article I.

B. Future Departments. When deemed appropriate, the Medical Executive Committee may recommend to the Board, and the Board may create anew, eliminate, subdivide, further subdivide, or combine departments.

2.03 Assignment to Departments

Each appointee of the staff shall be appointed to one or more Medical Staff departments, and may be granted clinical privileges in one or more of the other departments. Departmental appointments shall be granted if the criteria established by that department, as identified on that department's application for appointment to the Medical Staff, are met. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of the department chairman.

2.04 Functions of Departments

The primary function delegated to each department is to implement, monitor and evaluate activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

A. provide a mechanism to monitor and evaluate the professional performance of individuals who have delineated privileges in the department. The purpose of the monitoring shall be to draw conclusions, formulate recommendations, and to initiate actions to improve the quality of patient care. Each department shall monitor clinical performance under its jurisdiction whether or not any particular practitioner is a member of that department.

B. establish guidelines for the granting of clinical privileges within the department and submit the recommendations required regarding the specific privileges each staff appointee or applicant may exercise and the specified services that each Limited Health Practitioner may provide.

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

D. coordinate the patient care provided by the department's appointees with nursing and ancillary patient care services and with administrative support services.

E. foster an atmosphere of professional decorum within the department appropriate to the healing arts.

F. submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning: (1) findings of the department's quality improvement activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and (3) such other matters as may be requested from time to time by the Medical Executive Committee.

G. meet at least two times annually for the purpose of receiving, reviewing, and considering monitoring and evaluation activities and the results of the department's performance improvement, risk management, and peer review activities, and of performing or receiving reports on other department and staff functions, and maintain minutes thereof.

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

Article III
OFFICERS

3.01 Officers of the Staff

A. Identification. The officers of the staff shall be a president, president-elect, and secretary.

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

C. Nominations. The Nominating Committee shall submit one or more qualified nominees for each office at the annual meeting. In addition, nominations shall be accepted from the floor.

D. Election. Officers shall be elected at the annual meeting of the staff each year. Only staff appointees accorded the prerogative to vote for general staff officers shall be eligible to vote.

E. Exceptions. Sections (C) and (D) above shall not apply to the office of president. The president-elect shall, upon the completion of his term of office in that position, immediately succeed to the office of president. If the president is reelected for a second term, the succession will occur at the expiration of the second term for which he was elected.

F. Term of Elected Officer. Each officer shall serve a one-year term, commencing on the first day of the Medical Staff year following his election. Each officer shall serve until the end of his term and until a successor is elected. An officer may not be reelected to the same office for more than three one-year consecutive terms.

G. Vacancies in Elected Office. Vacancy in the office of secretary shall be filled by the Medical Executive Committee. If there is a vacancy in the office of president, the president-elect shall serve out the remaining term. A vacancy in the office of president-elect shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible.

H. Duties of Elected Officers.

(1) President. The President (who shall also be the Chief of Staff) shall serve as the chief administrative officer and principal elected official of the Staff. As such, he shall:

(a) aid in coordinating the activities and concerns of the Hospital Administration and of the Nursing and other patient care services with those of the Medical Staff.

(b) be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital, and for the effectiveness of the ongoing performance improvement and peer review processes.

(c) select and appoint the chief of each department and service.

(d) select and appoint the members and chairman of each committee of the Staff.

(e) communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board and the President/CEO.

(f) be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, Policy on Limited Health Practitioners, and provisions of the Medical Staff Organizational Manual for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

(g) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

(h) serve as chairman of the Medical Executive Committee and as an ex officio member of all other committees.

(i) be the spokesman of the Medical Staff in its external professional public relations.

(2) President-Elect. The President-Elect shall be the Chairman of the Credentials Committee. In the temporary absence of the President, he shall assume all the duties and have the authority of the President. He shall perform such additional duties as may be assigned to him by the President, the Medical Executive Committee, or the Board.

(3) Secretary. The Secretary shall be a member of the Credentials Committee and shall perform such duties as ordinarily pertain to his office. He shall prepare or cause to be prepared accurate and complete minutes for all meetings of the Staff and the Medical Executive Committee, and shall forward a copy of all minutes to the President of the Medical Staff and the President/CEO.

I. Removal of Officers or members of the MEC. A Medical Staff officer or member of the MEC may be removed from office for any of the following reasons, which shall be inclusive and not exclusive:

(1) failure to carry out the responsibilities of the office;
(2) failure to regularly attend meetings;
(3) voluntary or involuntary termination of Medical Staff appointment;
(4) involuntary reduction, suspension, or revocation of clinical privileges;
(5) finding of unprofessional conduct;
(6) such other reasons as may be determined under the facts and circumstances.

Removal of an officer of the organized Medical Staff may be initiated by a written statement from the Medical Executive Committee or by a written statement signed by no less than ten active appointees of the organized Medical Staff. The written statement shall specifically state the reasons why removal of an officer is requested and shall be delivered to the Immediate Past President of the Medical Staff who is still an active appointee. A copy of the written statement shall be promptly delivered by the Immediate Past President of the Medical Staff, to the officer sought to be removed, and to the President/CEO. Upon receipt of the written statement, the Immediate Past President shall promptly establish an ad hoc committee. This committee shall be composed of the three most recent Past Presidents of the Medical Staff, which are still active appointees, exclusive of all Past Presidents who are currently serving on the Medical Executive Committee.

This committee shall, within 15 days of the receipt of the written statement, meet, select a chairman and select a hearing date. The committee chairman shall notify the officer whose removal is being sought, one or more of the signatories to the statement, and the President/CEO of the date, time and place of the hearing. The hearing date shall not be less than 15 days nor more than 30 days from the date of the written request. The hearing procedure shall, insofar as reasonably applicable, conform substantially to the requirements of Article X of these Bylaws.

Following the hearing, the committee shall make a report of the hearing, together with its recommendations. This report and recommendations shall be made to the Medical Staff at a special meeting called for that purpose. After receiving the report and recommendations, the presiding officer shall entertain a motion calling for the removal of the officer. Removal shall require an affirmative two-thirds vote of the active Medical Staff appointees present and voting on the motion. The action of the Medical Staff is final and no appeal is permitted.

3.02 Department Chairman

A. Qualifications. Each chairman shall be an appointee of the active staff who is (1) certified by an appropriate specialty board, or (2) has affirmatively established competence through the credentialing process, and shall be willing and able to faithfully discharge the functions of his office.

B. Selection. Departments may make recommendations to the President of the Staff of individuals to be considered for the position of chairman of the department. However, ultimate selection and appointment of the chairman of each department shall be made by the President of the Staff, subject to the approval of the Board.

C. Term of Office. A department chairman shall serve a one-year term commencing on his appointment. He shall serve until the end of the Medical Staff year and until his successor is chosen. A department chairman shall be eligible to succeed himself, but may serve no more than three full terms in office in succession without the consent of the Medical Executive Committee. Removal of a department chairman from office may be initiated by the Board acting upon its own recommendation, or upon the recommendation of the Medical Executive Committee.

D. Responsibilities. Each chairman shall be accountable to the Medical Executive Committee and the Board of Trustees for:

(1) all clinically related activities of the department.

(2) administratively related activities of the department, unless otherwise provided for by the Hospital.

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

(4) making recommendations to the Medical Staff regarding the criteria for clinical privileges that are relevant to the care provided in the department.

(5) recommending clinical privileges for each member of the department.

(6) assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the organization.

(7) the integration of the department or service into the primary functions of the organization.

(8) the coordination and integration of interdepartmental and intradepartmental services.

(9) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services and patient safety.

(10) the recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(11) the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

(12) the continuous assessment and improvement of the quality and safety of patient care, treatment, and services provided. This responsibility may be shared with or delegated to a Section Chairman or the Physician Excellence Committee.

(13) the maintenance of quality control programs, as appropriate.

(14) the orientation and continuing education of all practitioners in the department or service.

(15) recommendations for space and other resources needed by the department or service.

(16) enforcing the Hospital and Medical Staff Bylaws, Rules and Regulations, and Policies and Regulations within his department (including initiating corrective action and investigation of clinical performance and ordering required consultations).

(17) implementing within his department actions taken by the Medical Executive Committee.

(18) performing such other duties commensurate with his office as may from time to time be reasonably requested of him by the President of the Staff, the Medical Executive Committee, or the Board.

Article IV
COMMITTEES AND FUNCTIONS

4.01 Designation and Substitution

There shall be a Medical Executive Committee and such other standing and special committees of the Staff responsible to the Medical Executive Committee as prescribed in these Bylaws and the Medical Staff Organizational Manual or as may from time to time be necessary and desirable to perform the staff functions listed in these Bylaws. The specific committee structure other than the Medical Executive Committee is set forth in the Organizational Manual. The Medical Executive Committee may, by resolution, and upon approval by the Board, establish a staff committee to perform one or more of the required staff functions. Those functions requiring participation of, rather than direct oversight by, the staff may be discharged by Medical Staff representation on such Hospital management committees as are established to perform such functions.

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

A. a named Medical Staff committee but no such committee shall exist, the Medical Executive Committee shall perform such function or receive such report or recommendation.

B. the Medical Executive Committee, but a standing or special committee shall have been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

4.02 Medical Executive Committee

A. Composition. The Medical Executive Committee shall consist of the President, President-elect, Secretary, and Immediate Past President of the Medical Staff, as well as the Chiefs of the Departments of Anesthesiology, Emergency Medicine, Family Practice, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Radiology and Surgery. The President or CEO of the Hospital and/or his designee attends each MEC meeting on an ex-officio basis without a vote.

B. Responsibilities. The organized Medical Staff delegates authority in accordance with law and regulation to enable the Medical Executive Committee to carry out the following responsibilities:

(1) receive, evaluate, monitor, and act upon reports and recommendations from the departments, committees, and officers of the Staff concerning the ongoing performance improvement and peer review activities, utilization of healthcare services, and the discharge of their delegated administrative responsibilities.

(2) coordinate the activities of and policies adopted by the Staff, departments and committees.

(3) recommend to the Board all matters relating to the structure of the Medical Staff, appointments, reappointments, suspension or termination of appointment, staff category, department and service assignments, the granting, suspension, or revocation of clinical privileges, specified services, and corrective action.

(4) account to the Board and to the Staff for the overall quality and efficiency of care rendered to patients in the Hospital.

(5) establish mechanisms by which appointment to the Medical Staff may be terminated and a mechanism for Fair Hearing procedures.

(6) make recommendations on medico-administrative and Hospital management matters.

(7) inform the Medical Staff of accreditation status, regulatory agency guidelines, and utilization management issues.

(8) participate in identifying community health needs and in setting Hospital goals and implementing programs and providing educational opportunities to meet those needs.

(9) represent and act on behalf of the organized Medical Staff, subject to such limitations as may be imposed by these Bylaws.

(10) act for the Medical Staff in the intervals between meetings of the organized Medical Staff.

(11) participate in organization performance improvement activities.

C. Meetings. The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

D. Quorum. The presence of five of the members shall constitute a quorum for the transaction of all business.

E. Manner of Action. The action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. An announcement on an issue that a member is “present” or “abstaining” shall not be considered as a vote on an issue.

F. Meeting Attendance Requirement. Each member of the Medical Executive Committee shall be required to attend at least fifty percent (50%) of all routinely and specially scheduled Medical Executive Committee meetings. The Committee may, subject to the approval of the Board of Trustees, remove any member who does not comply with this provision, and appoint a physician representative from the Department affected to fulfill the unexpired portion of the term.

4.03 Staff Functions

Provisions shall be made, either through assignment to the departments, to the Staff committees, or to interdisciplinary Hospital committees, for the effective performance of the organized Medical Staff functions required by these Bylaws, and of such other staff functions as the Medical Executive Committee or the Board shall reasonably require. Upon recommendation of the Medical Executive Committee and approval of the Board, committees created to perform these staff functions may meet and function jointly with a like committee of St. Francis Medical Center. The organized Medical Staff functions shall be to:

A. coordinate, monitor, evaluate, draw conclusions, formulate recommendations, and initiate actions on all departmental ongoing performance improvement and peer review activities and utilization of healthcare services in agreement with the Peer Review Process and Southeast Hospital Physician Expectations.

B. conduct monthly reviews of surgical and other invasive procedures.

C. establish a medication usage evaluation program, designed to continuously improve the appropriateness and effective use of drugs.

D. establish a mechanism by which the pharmacy and therapeutics functions are accomplished, which include development and approval of policies and procedures and maintenance of drug formulary.

E. perform blood usage review to continuously improve the appropriateness and effectiveness with which blood and blood components are used.

F. require that patient medical and related records are complete, timely, and clinically pertinent.

G. coordinate and review credentials investigations and recommendations regarding staff appointments and grants of clinical privileges and of specified services.

H. develop clinical policy for all clinical areas in the Hospital.

I. provide continuing education and supervise the Hospital's professional library services.

J. participate in other review functions which include a plan for internal and external disasters, Hospital safety, utilization review, and infection control.

K. develop and use criteria that identifies deaths in which an autopsy is performed.

L. as part of the Hospital's performance improvement program and annual reappraisal, evaluate the effectiveness of all functions.

M. provide leadership in all organization performance activities related to processes primarily dependent upon the activities of Medical Staff appointees.

N. measure, assess, and improve the appropriateness of clinical practice patterns.

O. establish mechanisms to identify significant departures from established patterns of clinical practice and approved privileges and to initiate corrective action where deemed appropriate.

P. oversee the process of analyzing and improving patient satisfaction

Q. provide oversight and assist with the creation of uniform standards to ensure patient safety and for the quality of care, treatment, and services provided by practitioners with privileges.

Article V
MEETINGS

5.01 General Staff Meetings

A. Regular Meetings. The regular annual staff meeting shall be held each year in the month of December. In addition, the Medical Staff shall hold regular meetings as needed.

B. Order of Business and Agenda. The order of business at a regular meeting shall be determined by the President of the Medical Staff. At the annual staff meeting, the agenda shall include at least:

(1) approval of the minutes of the meetings since the last regular meeting, unless by vote of the Staff, the reading is waived.

(2) the election of officers of the Staff.

(3) other business.

C. Special Meetings. Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, the Medical Executive Committee, or not less than ten appointees of the active staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

5.02 Committee and Department Meetings

A. Regular Meetings. Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

B. Special Meetings. A special meeting of any committee or department may be called by, or at the request of, the chairman thereof, the Board, the President of the Medical Staff, or by one-third of the group's then current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C. Notice of Meetings. Written notice stating the date, time, and place of any general staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat, so as to be received not less than seven days nor more than thirty days before the date of such meeting. Notice of department or committee meetings may be given orally. If mailed, the notice shall be deemed received forty-eight hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

D. Quorum.

(1) General Staff Meetings. The presence of ten (10) percent of the voting members of the active Medical Staff at any regular or special meeting shall constitute a quorum for the transaction of all business.

(2) Department Meetings. Those voting members of the department present and voting, and in no event less than two members, is considered a quorum at any meeting of such department.

(3) Committee Meetings. Other than for the Medical Executive Committee, those voting members of a committee present and voting, and in no event less than two members, shall constitute a quorum at any meeting of such committee.

E. Manner of Action. Department meetings and Medical Staff Committees comprised of physician members only shall act by the affirmative vote of a majority of the members present and voting. Participation by teleconference or other electronic means is permissible provided

all persons participating in the meeting can simultaneously hear or read each other's communications during the meeting. All other actions shall be handled in the manner described in Section 2.02 of the Medical Staff Organizational Manual.

F. Minutes. Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, forwarded to the Medical Executive Committee, and made available to the Staff and the President/CEO. A permanent file of the minutes of each meeting shall be maintained.

G. Attendance Requirements.

(1) Regular Attendance. Unless exempt from the basic responsibility pursuant to Section 6.04 (D) of the Medical Staff Bylaws, and except as to the attendance requirement applicable to members of the Medical Executive Committee and the Credentials Committee, each member of the Medical Staff shall be encouraged to regularly attend meetings of the Medical Staff and each department, service, and committee to which he is assigned to provide the expertise necessary to enable the department, service, or committee to appropriately discharge its responsibilities.

Article VI
MEDICAL STAFF APPOINTMENT

6.01 Nature of Medical Staff Appointment

No physician, dentist, or podiatrist shall admit or otherwise provide medical or health-related services to patients at Southeast Hospital unless he has been appointed to the Medical Staff or has been granted privileges pursuant to these Bylaws. Medical Staff appointment shall confer upon the Appointee a privilege in the nature of a license to exercise only such clinical privileges and prerogatives within the Hospital as are specifically granted by the Board of Trustees in accordance with the Bylaws of the Medical Staff.

6.02 Right of Hospital to Limit Medical Staff Appointments and Privileges

The Board of Trustees shall have the authority to limit the number of Medical Staff Appointees within particular departments, subspecialties and services of the Hospital, and to contract exclusively for the provision of any Hospital services.

6.03 Basic Qualifications for Appointment

A. Basic Qualifications. Only physicians, dentists, and podiatrists currently licensed to practice in the State of Missouri who:

(1) document their background, relevant experience and training, demonstrated ability to perform requested privileges, current professional competence and conduct and, upon request, their physical and mental health status, with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care, treatment, and services in a cost effective and efficient manner;

(2) are determined, on the basis of documented references, to 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; and

(3) provide evidence of professional liability insurance in an amount determined by the Board or other evidence of financial responsibility satisfactory to the Board;

shall be qualified for appointment to the Medical Staff. Only the Board may create exceptions to the qualifications for membership and/or privileges after consultation with the MEC.

B. Effect of Other Affiliations. No individual is automatically entitled to appointment to the Medical Staff or to exercise any clinical privileges merely because he is licensed to practice in any state, or because he is a member of any professional organization. Further, no individual shall be automatically entitled to appointment because he is certified by a clinical examining board, or because he has, or had, clinical privileges or staff membership at another hospital.

C. Nondiscrimination. Appointment to the Medical Staff or the granting of particular clinical privileges shall not be denied on the basis of sex, race, creed, color, or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community or Hospital needs.

6.04 Basic Responsibilities of Staff Appointment

Each appointee to the Medical Staff shall:

A. provide for the continuous care of his patients consistent with the generally recognized standard of care in the local medical community in terms of the level of quality and efficiency in a cost effective and efficient manner. This responsibility shall obligate the practitioner to make arrangements for alternative coverage for the care of patients during any period of time that the practitioner is unavailable.

B. unless appointed to the courtesy staff or honorary staff, designated as an affiliate physician, or otherwise excused by the Medical Executive Committee in advance, participate in the physician emergency call program, and when “on call” shall promptly and appropriately provide emergent medical consultation/patient care.

C. abide by the Medical Staff Bylaws and by all other lawful standards, policies, and rules and regulations of the Hospital.

D. discharge such staff, department, service, committee, and Hospital functions for which he is responsible by appointment, election, or otherwise.

E. prepare and complete in a timely manner all medical and other required records for all patients he admits or in any way provides care to in the Hospital.

F. abide by the ethical principles of his profession.

G. promptly notify the President of the revocation or suspension of his professional license by any state, or of his loss of staff membership or privileges at any hospital or other healthcare institution, or of the commencement of a formal investigation, or to the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Missouri, or any other governmental entity.

6.05 Duration of Appointment

A. Duration and Renewal of Initial and Modified Appointments. All initial appointments and modifications of appointments initially granted shall be for a period of twelve months. Renewals of provisional appointments shall be for a period of six months.

B. Reappointments. Reappointments to any category of the Medical Staff shall be for a period of not more than two years. Practitioners whose last names begin with A-L shall be subject to reappointment for a two year period effective January 1 of each year of even number. Practitioners whose last names begin with M-Z shall be subject to reappointment for a two year period effective January 1 of each year of odd number.

6.06 Appointment is Provisional

A. Initial Appointment. Except as otherwise determined by the Board, all initial appointments to any category of the staff, except active and honorary, shall be provisional and shall be for a minimum of six months during which a focused professional practice evaluation will be conducted. Each provisional appointee shall be assigned to one or more departments where his performance shall be observed by the chairman of the department or such chairman's designee, and may be observed by a committee of department members appointed by the chairman, to determine his eligibility for non-provisional staff appointment in the staff category to which he was provisionally appointed and for exercising the clinical privileges provisionally granted. An initial appointment and renewal thereof shall remain provisional until the appointee has furnished to the Credentials Committee and to the President/CEO:

(1) a statement signed by the chairman of each department to which he is assigned evaluating the activities of the appointee, including comments concerning his qualifications, the extent to which he has discharged his responsibilities, and whether or not he has exceeded or abused the prerogatives of the staff category to which he was provisionally appointed; and

(2) a statement signed by the chairman of the department that evaluates the appointee's ability to exercise the clinical privileges provisionally granted to him.

B. Provisional Changes. The Medical Executive Committee may recommend to the Board that a change in staff category of a current Staff appointee or the granting of additional privileges to a current Staff appointee be made provisional in accordance with procedures similar to those for initial appointments.

C. Renewals. Provisional appointments may not be renewed for more than two six-month periods. If the provisional Appointee fails within that period to furnish the statements required in Section (A) above, his staff membership or particular clinical privileges, as applicable, shall be reviewed by the Medical Executive Committee at its next regular meeting. The appointee so affected shall be given special notice of such meeting. At such meeting, the staff membership or particular clinical privileges shall be automatically terminated unless extended by the Medical Executive Committee for not more than three additional months.

Article VII
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

7.01 General Procedure

For purposes of this Article, the term "Hospital representative" includes the Board, its Trustees and Committees; the President/CEO; all Medical Staff appointees, departments, and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his application; and any authorized representative of any of the foregoing.

A. Application for Initial Appointment. Each prospective applicant shall provide preliminary information to the President/CEO to include the applicant's name, address, educational degree (MD, DO, DDS, DMD, or DPM), clinical residency program completed, specialty

certification, address of principle place of business, the name of the clinic, group practice, professional corporation, limited liability company or other entity, if any, with which the prospective applicant has established or intends to establish an affiliation and past and present medical staff affiliations. The President/CEO shall determine if the prospective applicant appears to meet the basic qualifications for appointment, and if so, the prospect shall be provided an application for appointment.

B. Upon Receipt of Application. The Medical Staff, through its designated departments, services, committees, and officers, shall investigate and consider each application for appointment or reappointment to the Staff and each request for modification of staff appointment status and shall adopt and transmit recommendations thereon to the Board.

7.02 Processing the Application

A. Application Form. Each application for appointment to the staff or request for privileges shall be in writing, submitted on the prescribed form, and signed by the applicant.

B. Content. The application form shall include:

(1) Acknowledgment and Agreement. A statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff and that he agrees to be bound by the terms thereof if he is granted appointment or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted appointment or clinical privileges.

(2) Qualifications. Detailed information concerning the applicant's qualifications.

(3) Requests. Specific requests stating the staff category, each department, and clinical privileges for which the applicant wishes to be considered.

(4) References. The names of at least three physicians who have worked with the applicant and observed his professional performance and who can provide references as to the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethical character, and ability to work with others.

When insufficient practitioner-specific data are available to evaluate an applicant for privileges, peer recommendations from a practitioner in the same professional discipline with personal knowledge of the applicant's ability to practice, will be obtained and evaluated. These recommendations will address relevant training and experience, current competence, and any effects of health status on privileges being requested.

(5) Professional Sanctions. For the purpose of this subsection, the applicant shall provide answers that reflect facts that are current as of the date the application is submitted whether such action occurred prior to the date of submission or is/are currently pending, and regardless of the outcome or current status of such action, and shall provide updates to such actions as they occur during the pendency of the application as well as after the application is approved.

(a) Information as to whether the applicant's Medical Staff status or clinical privileges have ever been revoked, voluntarily or involuntarily suspended, limited, reduced, terminated, or not renewed at any other hospital or healthcare institution;

(b) Information as to whether the applicant has voluntarily or involuntarily withdrawn an application for appointment, reappointment, and clinical privileges, or resigned

from the Medical Staff before a final decision by a hospital's or healthcare facility's governing board;

(c) Information as to whether any of the following have ever been challenged, suspended, revoked, denied, or voluntarily suspended or relinquished:

(i) membership/fellowship in local, state, or national professional organizations;

(ii) specialty board certification;

(iii) license to practice his profession in any jurisdiction;

(iv) Drug Enforcement Administration (DEA); or

(v) Any state narcotics registration, Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) registration number.

If any such actions were ever taken, the particulars thereof shall be included.

(6) Professional Liability Insurance. Evidence that the applicant carries at least the minimum amount of professional liability insurance coverage as required by the Hospital and information on his malpractice experience, including a consent to the release of information by his present and past malpractice insurance carrier(s).

Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant will be evaluated.

(7) Health Status. Documentation as to the applicant's health status.

(8) Physician Specific Data. Relevant practitioner-specific data are compared to aggregate data, when available.

(9) Morbidity and Mortality Data. Morbidity and mortality data, when available.

(10) Notification of Releases and Immunity Provisions. Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions.

(11) Administrative Remedies. A statement whereby the applicant agrees that, when an adverse ruling is made with respect to his staff appointment, staff status, or clinical privileges, he will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

7.03 Effect of Application

By applying for appointment to the Medical Staff, the applicant:

A. certifies that all statements made on the application are true.

B. attests to the fact that no health problems exist that could affect his ability to perform the privileges requested.

C. acknowledges/recognizes that he has the burden and responsibility for providing all information necessary to consider his application for appointment.

D. signifies his willingness to appear for interviews in regard to his application.

E. authorizes Hospital representatives to consult with others who have been associated with him or who may have information bearing on his competence and qualifications.

F. consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional qualifications and ability to carry out the clinical privileges he requests, as well as of his professional ethical qualification for staff appointment.

G. releases from any liability and agrees to hold harmless all Hospital representatives for their acts performed in connection with evaluating the applicant and his credentials, and thereafter for conducting ongoing and focused professional practice evaluation.

H. releases from any liability and agrees to hold harmless all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, ability to work with others, and other qualifications for staff appointment and clinical privileges.

I. authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care, with any information relevant to such matters the Hospital may have concerning him, and releases Hospital representatives from liability for so doing.

J. pledges that he will abide by the ethics of each organization of which he is a member and, in addition, pledges that he will:

(1) refrain from fee splitting or other inducements relating to patient referral;

(2) provide for continuous care of his patients;

(3) refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;

(4) seek consultation whenever necessary; and

(5) refrain from providing "ghost" surgical or medical services.

7.04 Processing the Application

A. Applicant's Burden. The applicant shall have the burden of producing adequate information for a proper evaluation of his licensure, experience, background, training, demonstrated ability, current physical and mental health condition as it affects his ability to practice medicine, and such other information as may reasonably be required by the Credentials Committee, Medical Executive Committee, or Board of Trustees. In addition to establishing the requisite knowledge, training, and experience applicable to the practice of medicine, (including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided), applicants shall demonstrate that they adhere to the ethics of their profession (including continuous professional development, an understanding of and sensitivity to diversity and a responsible attitude toward patients and their profession), that their reputation and character reflect mental and emotional stability, that they are in such physical condition to carry out their responsibilities, and that they have the ability to work harmoniously with others as a member of the healthcare team (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). Applicants shall have the burden of resolving any doubts about these or any of the other basic qualifications required for Medical Staff appointment. Incomplete applications will not be processed. Significant misstatements or omissions on the application shall be grounds for stopping the processing of the application, or if such omissions or misstatements are discovered after the application has been granted, for revocation of privileges or appointment. If privileges or appointment are revoked for misstatements or omissions on the application, the applicant or practitioner shall not be entitled to the procedural rights set forth in the Fair Hearing Plan.

B. Verification of Information. The applicant shall deliver his completed application to the President/CEO, who shall seek to collect or verify through the original source whenever possible, the references and other qualification evidence submitted to confirm current license status, training, experience, competence and ability to perform the requested privilege(s). The President/CEO shall promptly, and in any event not later than 90 days from receipt of the application, notify the applicant of any extraordinary delay, difficulty obtaining or inadequate response from references, past hospitals or affiliations that render the application incomplete. Applications which remain incomplete after the expiration of ninety (90) days after notification of deficiencies shall be deemed to have been withdrawn. When collection of references and verification is accomplished and the application is deemed complete, the applicable department and/or section chairpersons shall be promptly notified that the applicant's file is available for review. The department and/or section chairperson shall then review the file, evaluate the applicant's statements and documentation collected in support of the application, and submit a written recommendation to the Chairperson of the Credentials Committee.

C. Department Action. The chairman of each applicable department and/or section shall review the application and supporting documentation and shall prepare and transmit their findings and recommendations to the Chairperson of the Credentials Committee within thirty (30) days of receipt of the application. A finding that the information contained in the application is insufficient to enable an evaluation of the application shall be promptly communicated to the President/CEO and the Credentials Committee. A department chairman may also recommend to the Credentials Committee that the Medical Executive Committee defer action on the application. The reason for each recommendation, except for a recommendation of approval as requested, shall be stated and supported by reference to the application and documentation considered by the chairman.

D. Credentials Committee Action. The Credentials Committee shall review the application, the supporting documentation, each department chairman's report and recommendations, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. Upon request of the Credentials Committee, the applicant shall appear for a personal interview. The Credentials Committee shall then transmit its findings and recommendations to the Medical Executive Committee and the President/CEO. The report shall specify, where applicable, staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also recommend that the Medical Executive Committee defer action on the application. The reason for each recommendation, except for a recommendation of approval as requested, shall be stated and supported by reference to the completed application and all other documentation considered by the Committee. Any minority views may also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

E. Medical Executive Committee Action. At the next regular meeting which occurs more than five days after receiving the report and recommendation from the Credentials Committee, the Medical Executive Committee shall consider the report and such other relevant information available to it. Upon request of the Medical Executive Committee, the applicant shall appear for a personal interview. The Committee shall forward to the President/CEO for transmittal to

the Board its findings and recommendations, including specifications as to staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also defer action on the application. The reasons for each recommendation, except for a recommendation of approval as requested, shall be stated and supported by reference to the completed application and all other documentation considered by the Committee. Any minority views may also be reduced to writing, supported by references and reasons, and transmitted with the majority report.

F. Effect of Medical Executive Committee Action. The effect of the Medical Executive Committee's action shall be as follows:

(1) Deferral. Action by the Committee to defer the application for further consideration must be followed up within forty days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff appointment.

(2) Favorable Recommendation. When the recommendation of the Medical Executive Committee is favorable to the applicant, the President/CEO shall promptly forward it to the Board.

(3) Adverse Recommendation. When the recommendation of the Medical Executive Committee is adverse to the applicant, the President/CEO shall immediately so inform the applicant by special notice. The applicant shall be entitled to the procedural rights as provided in Article X.

G. Board Action.

(1) On Favorable Recommendation. The Board shall adopt or reject, in whole or in part, a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant, the President/CEO shall promptly so inform the applicant by special notice. The applicant shall be entitled to the procedural rights as provided in Article X of these Bylaws.

(2) Without Benefit of Medical Executive Committee Recommendation. If the Board does not receive a Medical Executive Committee recommendation after the Medical Executive Committee has reviewed the application, it may take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse to the applicant, the President/CEO shall promptly so inform the applicant by special notice. The applicant shall be entitled to the procedural rights as provided in Article X.

(3) After Procedural Rights. In the case of an adverse Medical Executive Committee recommendation or an adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article X. Action thus taken shall be the decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a decision either to appoint the applicant to the staff or to reject him for staff appointment.

H. Conflict Resolution. Whenever the Board's initial decision will be contrary to the Medical Executive Committee's recommendation, the Board shall submit the matter to a special joint committee consisting of five members of the Medical Staff selected by the President of the Medical Staff and five members of the Board selected by the President of the Board for review and recommendation. The special joint committee shall meet at a time designated by the President of the Board and make its recommendation within ten days thereafter. The Board shall receive the recommendation of this special joint committee before making its final decision.

I. Notice of Final Decision.

(1) Notice of the Board's final decision shall be given through the President/CEO to the applicant by means of special notice, and to the chairmen of the Medical Executive and the Credentials Committees, as well as to the chairman of each department concerned.

(2) A decision and notice to appoint shall include: (1) the staff category to which the applicant is appointed; (2) each department to which he is assigned; (3) the clinical privileges he may exercise; (4) any special conditions attached to the appointment, and (5) the reason for any denial.

J. Reapplication After Adverse Appointment Decision. An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of twelve months following the final decision of the Board, or if the final decision is appealed to the courts, twelve months following the final judgment of the court. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

K. Time Period for Processing. Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups, and, except for good cause, shall be processed within the following time periods:

(1) The President/CEO shall transmit an application upon completing his information collection and verification tasks, but in any event within sixty days after receiving the application.

(2) The department chairman shall act on an application within thirty days after receiving it from the President/CEO.

(3) The Credentials Committee shall act on the application within one hundred days after receiving it from the President/CEO.

(4) The Medical Executive Committee shall review the application and make recommendation to the Board within forty-five days after receiving the Credentials Committee report.

(5) The Board or its Executive Committee shall take action on the application at its next regular meeting after receiving the application from the Medical Executive Committee.

7.05 Reappointment Process

A. Information Form for Reappointment. The President/CEO shall, at least 90 days prior to the expiration date of the present staff appointment of each Medical Staff appointee, provide such

staff appointee with an application form for use in considering reappointment. Each staff appointee and practitioner holding privileges who desires reappointment shall, at least 60 days prior to such expiration date, send his reappointment application form to the President/CEO. Medical Staff appointees and practitioners who hold privileges who do not return the application form and required supporting documentation within the described time frame may experience an interruption in appointment and privileges. Failure to return the form shall result in expiration of appointment and/or privileges at the expiration of the current appointment cycle.

B. Content of Form. The reappointment application form shall be a prescribed form and shall contain information necessary to maintain as current the Medical Staff file on the staff appointee's healthcare related activities. This form shall include, without limitation, information about:

(1) current licensure and U.S. Drug Enforcement Administration (DEA) and Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) registration, including information related to previously successful or currently pending challenges or voluntary relinquishment of such licenses or registrations.

(2) continuing training, education, and experience that establishes the Staff Appointee's current ability to perform the privileges sought on reappointment.

(3) membership, awards, or other recognitions conferred or granted by any healthcare organization.

(4) sanctions of any kind imposed by any other healthcare institution including voluntary or involuntary termination of membership and voluntary or involuntary limitation, reduction, or loss of clinical privileges.

(5) details about malpractice insurance coverage, claims, suits, judgments, and settlements.

(6) upon specific request by the Medical Executive Committee or the Board, current physical and mental health condition as it relates to the applicant's ability to exercise the privileges requested .

C. Verification of Information. The President/CEO shall seek to collect or verify the additional information. The President/CEO shall transmit the information form and supporting materials to the chairman of each department in which the staff appointee requests privileges.

D. Professional Competence. The President/CEO shall obtain information concerning the practitioner's professional competence as evidenced through practitioner-specific data that reflects peer review/performance improvement activities, including ongoing and focused professional practice evaluation, and including information concerning procedures performed and their outcomes, medication usage, blood usage, medical records, and other activities as appropriate, and the practitioner's continued satisfaction of the factors set forth in Section 7.04 (A).

If practitioner-specific data are insufficient or not available, peer recommendations will be obtained and evaluated. These peer recommendations will be obtained from a practitioner in the same professional discipline with personal knowledge of the applicant's ability to practice. These recommendations will address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, relevant training and experience, current competence, and any effects of health status on privileges being requested.

E. Department Actions. Each department chairman shall review the information form and the staff appointee's file and shall transmit to the Credentials Committee, prior to the December Committee meeting of each year, his recommendation that appointment be renewed, renewed with modifications, or terminated.

F. Credentials Committee Action. The Credentials Committee shall review each form and the recommendation of each department in which the staff appointee has requested privileges. It shall transmit to the Medical Executive Committee its report and recommendations.

G. Medical Executive Committee Action. The Medical Executive Committee shall review each information form and all other relevant information available to it. The Committee shall forward to the President/CEO for transmittal to the Board its report and recommendation that appointment be renewed, renewed with modifications, or terminated. The Committee may also defer action.

H. Final Processing and Board Action. Thereafter, the procedure provided in Section 7.04 (G) shall be followed.

I. Basis for Recommendations. Each recommendation concerning the reappointment of a Medical Staff appointee and the clinical privileges to be granted upon reappointment shall be based upon such appointee's current professional ability and clinical judgment in the treatment of patients; his professional ethics; his discharge of staff obligations; his compliance with the Medical Staff Bylaws and Rules and Regulations; his cooperation with other practitioners, Hospital employees, and with patients; and other matters bearing on his ability and willingness to contribute to good patient care practices in the Hospital.

J. Time Periods for Processing. Each person, department, and committee shall complete such action in timely fashion such that all reports and recommendations shall have been transmitted to the Medical Executive Committee for its consideration and action at its December meeting. The Medical Executive Committee shall transmit its recommendations to the Board for Board action at its December meeting.

K. Conditional Reappointments.

(1) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements).

(2) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

(3) In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle a practitioner to the procedural rights set forth in Article X.

7.06 Requests for Modification of Appointment

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department, or clinical privileges by submitting a written application to the President/CEO on the prescribed form. Such application shall be processed in substantially the same manner as provided for reappointment.

Article VIII
DETERMINATION OF CLINICAL PRIVILEGES

8.01 Exercise of Privileges

Every practitioner or other professional providing direct clinical services at this Hospital by virtue of Medical Staff appointment or otherwise, shall, in connection with such practice and except as provided in Sections 8.06 and 8.07 hereof, be entitled to exercise only those clinical privileges or specified services specifically granted to him by the Board.

Any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm and shall be assisted by Hospital personnel in doing so—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

8.02 Delineation of Privileges in General

A. Requests. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by applicant.

B. Basis for Privileges Determination.

Clinical Competence: Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same. The basis for privileges determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the ongoing performance improvement program, including ongoing and focused professional practice evaluation, required by these and the Hospital Corporate Bylaws to be conducted at the Hospital. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where a practitioner exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for a staff appointee.

C. Procedure. All requests for clinical privileges shall be processed pursuant to the procedures for appointment and reappointment as in Article VII.

D. Resources to Support Requested Privileges: Requests for clinical privileges not previously carried out at the Hospital will be evaluated to determine if resources are in place, at what location within the institution the privilege will be exercised, and when necessary, the credentialing criteria a practitioner will be required to meet in order to be eligible to apply for the privilege.

8.03 Special Conditions for Part-time Physicians under Contract with the Hospital

Requests for clinical privileges from part-time physicians under contract with the Hospital shall be processed in the manner specified in Article VII. All procedures performed by such physicians shall be under the overall supervision of the chief of the department in which the privileges are granted. Such physicians are not eligible for appointment to the Medical Staff and have no rights under Article X of these Bylaws.

8.04 Special Conditions for Dental or Podiatric Privileges

Requests for clinical privileges from dentists or podiatrists shall be processed in the manner specified in Article VII. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chief of Surgery. All dental or podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

8.05 History and Physical Requirements (Refer to Medical Staff Rules and Regulations, Articles VII and VIII for Further Detail)

A. A history and physical examination shall be completed on each of the following categories of patients:

(1) inpatients
(2) observation patients
(3) outpatients undergoing any kind of surgery
(4) outpatients undergoing an invasive procedure
(5) outpatients who will receive sedation analgesia.

B. The history and physical examination shall be completed by an appropriately privileged physician, oral maxillofacial surgeon, podiatrist, or allied health practitioner to whom the responsibility has been delegated.

C. Emergency Department physician notes or other reports of E.D. physicians shall not be used in lieu of the admitting or attending physician's own history and physical report. Every physician who admits an inpatient or is primarily responsible for treatment of an outpatient as described in 5.02 (A) of the Medical Staff Rules and Regulations shall perform a history and physical examination and prepare a report of the same. The admitting or attending physician may delegate this responsibility to another practitioner who has been appropriately granted privileges to do so.

D. Appropriately privileged dentists, oral maxillofacial surgeons, or podiatrists are responsible for the disease/procedure specific medical appraisal of the dental or podiatric patient, regardless of whether they have been granted comprehensive medical History and Physical privileges.

E. The time frame for completion of the history and physical examination is as follows:

(1) A history and physical examination shall be recorded and/or dictated and placed in the medical record on each inpatient or observation patient within twenty-four (24) hours of admission to the hospital. A history and physical examination completed no more than 30 days prior to the procedure is acceptable; however, an update to the patient's condition since it was last assessed is required at the time of admission and must be placed in the medical record within 24 hours of admission.
(2) The medical record of any outpatient or observation patient presenting for surgery, an invasive procedure, or any procedure involving sedation analgesia must contain a history and physical examination prior to the procedure being performed, except in an emergency. When the history and physical has been performed prior to the day of the procedure, there must be an update to the patient's condition entered into the record by an appropriately privileged practitioner prior to the start of the procedure.
(3) In the situation where the patient is going to surgery within the first 24 hours of admission and the H&P was completed prior to admission, then the update to the patient's condition and the pre-anesthesia assessment will be accomplished in a combined activity.
(4) Completion of the Short Stay H&P (as approved by the MEC) is acceptable for an

outpatient or observation patient presenting for surgery, an invasive procedure, or any procedure involving sedation analgesia.

(5) A history and physical examination completed by an appropriately privileged allied health practitioner must be authenticated by the collaborating/supervising physician by the time the medical record is otherwise complete.

8.06 Temporary Privileges

A. Circumstances. Upon the concurrence of the President of the Medical Executive Committee or his authorized designee, the President/CEO or his authorized designee may grant temporary privileges in the following circumstances:

(1) New applicants for staff appointment: An appropriately licensed applicant may be granted temporary privileges for 120 days following the Credentials Committee's recommendation of approval, while awaiting review and recommendation by the Medical Executive Committee and approval by the Executive Committee of the Board of Trustees. The application must be complete and completely verified; the National Practitioner Data Bank must have been queried and results considered; and the applicant must have had no actions undertaken that are adverse to licensure or registration, medical staff membership at another organization, or clinical privileges—as further detailed in the Temporary Privileges Policy and Procedure. Current licensure, relevant training and experience, and competence must have been verified prior to issuance of these privileges. In exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he is assigned.

(2) Care of Specific Patient(s): An appropriately licensed practitioner who is not an applicant for appointment may be granted temporary privileges for the care of one or more specific patients to meet an important patient care, service, or treatment need. Such privileges shall be restricted to the treatment of not more than five patients or for a period of not more than 120 days in any one year by any practitioner, after which such practitioner shall be required to apply for appointment to the Medical Staff before being allowed to attend additional patients. A completed application must have been received and current licensure and competence must have been verified prior to issuance of these privileges.

(3) Locum Tenens: An appropriately licensed practitioner who is serving as a locum tenens for an appointee of the Medical Staff, to provide coverage for a service or for the Hospital may, without applying for appointment to the staff, be granted temporary privileges for a period of 120 days to meet an important patient care, service, or treatment need. A completed application must have been received and current licensure and competence must have been verified prior to issuance of these privileges.

Privileges will not be granted beyond the initial 120 days until the application verification and approval process has been completed and the Board of Trustees has acted to approve the granting of privileges. Granting of privileges to facilitate subsequent periods of coverage will not be considered temporary. Processing and reappraisal activities are detailed in a policy separate from these bylaws.

B. Conditions. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the applicant's qualifications, ability, and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the President of the Medical Staff.

C. Termination. On the discovery of any information or the occurrence of any event of a professionally questionable nature about an applicant's qualifications or ability to exercise any or all of the temporary privileges granted, the President/CEO may, after consultation with each

department chairman or the President of the Medical Executive Committee, terminate any or all of such applicant's temporary privileges.

D. Rights of the Applicant. An applicant shall not be entitled to the procedural rights granted by Article X because of his inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

8.06 Emergency and Disaster Privileges

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

A. In the case of an emergency or disaster (any emergency officially declared such by Hospital Administration or local, state, or national authorities that causes the Hospital to implement its Disaster or Emergency Management Plan), practitioners (physicians, dentists and podiatrists) who are not members of or hold appointment to the Medical Staff of Southeast Hospital may be granted emergency or disaster privileges. These privileges may be granted only when the Hospital has implemented its Disaster or Emergency Management Plan and the Hospital has determined that the immediate needs of the patients cannot be met by existing staff. These privileges shall be granted by the President/CEO or Chief of Staff, or designee of either.

Approval is required prior to provision of patient care. A badge will be issued to signify approval and to identify the individual as Volunteer Medical Staff.

The practitioner granted emergency or disaster privileges will act only under the supervision of a currently credentialed Medical Staff Member who will evaluate the volunteer granted disaster privileges and recommend continuance or discontinuance of privileges within 72 hours of issuance and periodically thereafter throughout the disaster situation. This decision will be based on his/her personal observation, on discussion with individuals who personally observed the provision of patient care services, or upon review of documentation of care provided.

B. Prior to approval of disaster privileges, a valid government-issued photo identification issued by a state or federal agency (i.e. driver's license or passport) and at least one of the following items will be collected and verified when possible:

(1) Current professional license to practice medicine, dentistry or podiatry in any state

(2) Current hospital photo identification card that clearly identifies professional designation

(3) Primary source verification of the professional license to practice

(4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups

(5) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

(6) Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a physician, dentist, or podiatrist during a disaster

Note: If primary source verification of licensure is not accomplished prior to the granting of disaster privileges, primary source verification will begin as soon as the immediate situation is under control and will be completed within 72 hours of the time the volunteer practitioner presents to the Hospital. When primary source verification cannot be completed within 72 hours due to some extraordinary circumstance (i.e. no means of communication or a lack of resources or other circumstance attributed to the disaster) that verification will be accomplished as soon as possible, the extraordinary circumstance and continued efforts to verify will be documented, and evidence of the volunteer's ability to provide adequate care, treatment and services will be documented.

C. Termination.

(1) When the emergency or disaster situation no longer exists, these temporary, emergency or disaster privileges terminate.

(2) On the discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner's qualifications or ability to exercise any or all of the privileges granted, the President/CEO may, after consultation with the appropriate department chairman or the President of the Medical Executive Committee, terminate any or all of such practitioner's emergency or disaster privileges.

8.07 Interpretive or Limited Outpatient Therapeutic Privileges of Affiliate, Non-staff Physicians

A. Physicians granted interpretive, telemedicine, or limited outpatient therapeutic privileges pursuant to this section shall be designated "Affiliate Physicians."

B. Eligibility Criteria. The Hospital Board of Directors, acting upon the recommendation of the Medical Executive Committee and the Credentials Committee, may grant interpretive, telemedicine, or limited outpatient clinical privileges to a physician who:

(1) does not hold an active or associate appointment to the medical staff, and
(2) is not a locum tenens physician; and
(3) does not satisfy the proximity requirement described in Section 10.01 of the Medical Staff Rules and Regulations.

C. Permitted Privileges. An Affiliate Physician credentialed under this section shall be granted interpretive, telemedicine, or limited outpatient therapeutic privileges.

(1) Interpretive privileges may include the following as appropriate to the physician's specialty and consistent with his qualifications and credentials.

(a) Interpretive privileges provided by a radiologist may include ultrasound, CT, nuclear medicine, or radiograph interpretations.
(b) Interpretive privileges provided by a pediatric cardiologist may include interpretation of EKGs and echocardiograms.
(c) Interpretive privileges provided by a pediatric neurologist may include EEG interpretations.

(2) Telemedicine privileges:
(a) May include diagnostic or treatment services via electronic communication link
(b) The Medical Staff at both the originating and distant sites must determine what clinical services, if any, will be provided through a telemedicine link at their respective sites. The Medical Staff shall make recommendations to the Hospital Board of Directors regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services.

(3) Limited therapeutic privileges may include the following therapeutic regimens, as appropriate to the physician's specialty and consistent with his qualifications and credentials:

(a) Chemotherapy
(b) Infusion therapy, including by way of example and not limitation, blood, blood products, IV antibiotics, IV steroids, and other IV medications such as Remicade.

D. Qualifications and Credentialing Requirements. An applicant for Affiliate Physician status shall provide the following information as part of the application process:

(1) Completed application for Affiliate Physician Status (Interpretive or Limited Outpatient Therapeutic)
(2) Current Missouri medical license
(3) Affiliate physicians who hold interpretive privileges must have a current medical license in the state from which interpretations are performed
(4) Current DEA and BNDD certificates if warranted by the privileges held
(5) UPIN number and/or NPI number
(6) List of therapeutic regimens for which patients will be referred or studies to be interpreted
(7) Copy of current medical malpractice insurance certificate.
(8) Documentation of staff and privilege status at a Joint Commission accredited hospital or ambulatory care facility.
(9) Government issued photo ID.
(10) For Telemedicine: If the telemedicine physician's site is also accredited by the Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician at Southeast Hospital.

E. Verification of Qualifications and Credentialing Requirements: Confirmation of licensure, education, training, and current competence shall be secured by Medical Staff Services as follows:

(1) Query Missouri Board of Registration for the Healing Arts (licensure) and when applicable, the state from which interpretations are performed
(2) Query the National Practitioner Data Bank (competence)
(3) Query the U.S. Department of Health and Human Services, Office of Inspector General list of excluded providers (competence).
(4) Query the AMA and/or AOA (education, training, competence)
(5) Query a medical facility at which the physician holds privileges (competence)
(6) Other documentation, satisfactory to the Credentials Committee, to establish that the Affiliate Physician has the requisite knowledge, training, and experience necessary to indicate competency to appropriately carry out the privileges granted. Evidence of competency may include specialty board certification and/or relevant training and experience gained in a Joint Commission or AOA currently accredited hospital--or ambulatory care facility in the case of teleradiology--in which the practitioner holds a current medical staff appointment with clinical privileges similar to the ones being requested. The Credentials Committee may request such other evidence as it may deem necessary to evaluate the physician's qualifications.
(7) For Telemedicine: obtain primary source verification of licensure, professional liability insurance, and query of the National Practitioner DataBank.

F. Review of Affiliate Status. Limited Clinical or Interpretive Privileges shall be granted for an initial period not to exceed two years. Such privileges may be renewed every two years upon favorable action on the request by the Credentials Committee and upon its recommendation

to the Medical Executive Committee subject to final approval of the Hospital Board of Directors.

G. Rights and Privileges of Affiliate Physician Status. Affiliate Physicians shall be entitled to the rights or privileges of due process accorded to practitioners holding active, associate, consulting, courtesy, or honorary appointments to the medical staff. Further, the Hospital Board of Directors shall determine in the exercise of its sole discretion whether the grant of limited clinical privileges to any physician is in the best interest of the hospital. Generally, "Affiliate" status is intended to accommodate patients who reside in the Hospital's service area and are under the care of a physician who does not maintain a medical practice in this community. Any limited clinical or interpretive privileges so granted shall be within the scope and authority of the practitioner's current Missouri license and practice act and the regulations promulgated at 19 CSR 30-20 (18).

8.08 Special Conditions for Residents or Fellows in Training

A. Physicians who are completing graduate medical education (residency or fellowships training) shall not hold an appointment to the Medical Staff nor be granted clinical privileges, but may be permitted to function in the clinical setting only in accordance with written training protocols approved by the academic institution's program director and the Credentials Committee. Such protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows, including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which the resident's program director and local supervising physician(s) make decisions about a resident's progressive involvement and independence in delivering patient care. Refer also to the Policy and Procedure: Medical Students, Residents, Advanced Practice Nurse Students, and Physician Assistant students Clinical and Observation Rotations.

The postgraduate education program director and Credentials Committee must communicate periodically with the Medical Executive Committee and the Hospital Board of Directors regarding the performance of residents, patient safety issues, and quality of patient care, and must work with said Committees to ensure that all local supervising physicians possess clinical privileges commensurate with the activities for which they are providing supervision. Proof of professional liability insurance covering the acts of the physician while engaged in post graduate medical education is required.

B. Requests for clinical privileges from part-time physicians under contract with the Hospital shall be processed in the manner specified in Article VII. All procedures performed by such physicians shall be under the overall supervision of the chief of the department in which the privileges are granted. Such physicians are not eligible for appointment to the Medical Staff and have no rights under Article X of these Bylaws.

Article IX
PROFESSIONAL COMPETENCE AND CONDUCT

9.01 Peer Review

A. Ongoing and Focused Professional Practice Evaluations. All ongoing and focused professional practice evaluations shall be conducted in accordance with the Medical Staff's peer review procedures. Matters that cannot be appropriately resolved through collegial intervention or through the peer review process shall be referred to the Credentials Committee or the Medical Executive Committee in accordance with Section 9.02 or 9.03.

B. Collegial Intervention.

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

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

(3) 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:

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

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(4) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual shall have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.

(6) The relevant Medical Staff leader(s), in conjunction with the President/CEO, shall 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 Credentials Committee or Medical Executive Committee for further action.

9.02 Preliminary Inquiry

A. Purpose. Whenever a question arises regarding the clinical competence or professional conduct of any practitioner, an inquiry may be made into the matter by requesting a preliminary focused review by the Credentials Committee. The preliminary inquiry provides an opportunity for a physician’s practice to be discussed in an informal setting. A preliminary inquiry is considered an administrative review and not an adversarial proceeding. As an administrative proceeding, the results of a preliminary inquiry are not reportable to the National Practitioner Data Bank nor to the Missouri Board of Registration for Healing Arts.

B. How Initiated. The preliminary review process may be initiated by any member of the Medical Staff, by the President/CEO or upon request of the Board of Trustees. The Chairman of the Credentials Committee upon receipt of a request for preliminary review shall then bring the matter before the Credentials Committee at any regular or special meeting.

C. Review Process. The Credentials Committee may conduct such preliminary inquiry as it deems necessary utilizing whatever methods of inquiry as it may determine appropriate, including the appointment of an ad hoc committee or the consultation of independent reviewers. The Credentials Committee shall notify the physician whose practice they are reviewing prior to initiating the review. The Committee may review and evaluate medical records, interview the practitioner, interview the practitioner's Hospital patients, interview Hospital's employees, interview other practitioners and solicit, receive, and evaluate information from other sources. If the Committee determines that the practitioner's clinical competence or professional conduct warrants investigation, such investigation shall be initiated pursuant to Section 9.03. If the Committee reasonably believes that the health or well-being of any patient is at risk, that the Hospital's capability to deliver quality medical care is or could be adversely affected, or that the Hospital's operations are being disrupted as the result of the practitioner's method of practice or course of conduct, the Committee shall initiate an investigation and make such recommendation to the Medical Executive Committee or the President/CEO as it deems necessary under the circumstances.

The Credentials Committee shall have sixty (60) days to complete its inquiry and report back to the requestor, the physician whose practice was reviewed, and to the Medical Executive Committee.

9.03 Peer Review Investigation

A. Purpose. The purpose of a peer review investigation is to review a specific concern or complaint regarding a practitioner's performance, including clinical competence, professional conduct, and behavior.

B. Initiation. An investigation shall be initiated upon request of the Credentials or Medical Executive Committee promptly communicated to the President of the Medical Staff, the President/CEO, and the practitioner whose professional competence or conduct is the subject of investigation. The investigation shall be performed by the physician's peers, consisting of an ad hoc committee appointed by the Chairperson of the Credentials Committee. The ad hoc committee shall have sixty (60) days to complete its inquiry and report back to the requestor, the physician whose practice was reviewed, and to the Medical Executive Committee. Any practitioner who has a conflict of interest as determined by the Hospital's Statement of Organizational Ethics shall declare such fact to the Chairperson of the Credentials Committee whereupon the Chairperson shall appoint another practitioner to serve in the place of the practitioner who has declared a conflict of interest. Members of the ad hoc committee shall be responsible for conducting an objective investigation free from personal bias or prejudice against the adversely affected physician.

C. Method of Investigation. The ad hoc committee appointed to conduct the investigation may utilize whatever means or methods it deems necessary under the circumstances, including but not limited to review of medical records, consultation with an independent reviewer, and the interviewing of the practitioner's Hospital patients, other practitioners, or Hospital's employees. The ad hoc committee may also solicit, receive, and evaluate information from other sources.

D. Report of Investigation. Upon conclusion of its peer review investigation, the ad hoc committee shall report its findings, conclusions, and recommendations in a preliminary report to the Credentials Committee. The Credentials Committee shall:

(1) Adopt or reject any part or all of the ad hoc committee's findings and recommendations, or cause further investigation to be conducted, or close the matter to further investigation; and

(2) Report its findings, conclusions, and recommendations in a preliminary report to the Medical Executive Committee. No investigatory report shall be considered final until approved by the Board of Trustees.

E. Action of the Medical Executive Committee. The Medical Executive Committee shall receive the report of findings, conclusions and recommendations of the Credentials Committee and take such action as it may deem necessary, including but not limited to:

(1) Adopting any or all of the Credential Committee's findings, conclusions, and recommendations;

(2) Rejecting any or all of the Credential Committee's findings, conclusions, and recommendations;

(3) Causing further investigation to be conducted using such methods and means of inquiry it may deem appropriate under the circumstances;

(4) Issuing a warning, a letter of admonition, or a letter of a reprimand;

(5) Recommending a performance improvement plan;

(6) Recommending the imposition of conditions, including requirements of consultation or peer review on a pre-procedure, concurrent or retrospective basis;

(7) Recommending reduction, suspension or revocation of clinical privileges; or

(8) Recommending suspension or revocation of staff appointment.

F. Medical Executive Committee Report to Board of Trustees. The Medical Executive Committee shall report its findings, conclusions, and recommendations to the Board of Trustees for final action.

G. Fair Hearing - Waiver of Fair Hearing. If the Medical Executive Committee recommends action which would entitle the practitioner to a fair hearing, then the practitioner shall be afforded the procedural rights set forth in the Fair Hearing Plan set forth in Article X of these Bylaws. If the right to a hearing is waived, then the Board of Trustees shall be notified that the proposed recommendation of the Medical Executive Committee is a final recommendation, and the Board of Trustees shall take final action after reviewing the final report.

H. Action of the Board of Trustees. The Board of Trustees shall consider any final report of the Medical Executive Committee and take such final action as it deems necessary. The procedures specified herein shall not preclude the Board of Trustees from taking any direct action or utilizing other methods for dealing with disruptive or other physician conduct which action either does not adversely affect clinical privileges or is based on factors other than physician competence or professional conduct.

9.04 Precautionary Suspension or Restriction

A. Commencement. Whenever there are reasonable grounds to believe that the conduct or activity of a practitioner poses a threat to the life, health, or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health, or safety of any such person, the President of the Medical Staff, the Medical Executive Committee, the President/CEO or the Chairman of the Board of Trustees may summarily suspend or restrict all or any portion of the practitioner's clinical privileges for such period of time as may be deemed necessary under the circumstances. It shall not imply any final finding of responsibility for the situation that caused the suspension or

restriction. Such precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO, the President of the Medical Staff, and the Chairperson of the Credentials Committee, and shall remain in effect unless or until modified by the Board of Trustees. The precautionary suspension or restriction shall become effective immediately and shall be deemed an interim precautionary step in the professional review activity, but is not a complete professional review action in and of itself. The President/CEO shall promptly give special notice of the suspension or restriction to the practitioner and to the Chairman of the Medical Executive Committee. A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing. The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any), within twenty-four (24) hours of the imposition of the suspension or restriction.

B. Action of Medical Executive Committee. The Medical Executive Committee shall be convened within fourteen (14) days of the precautionary suspension or restriction of privileges of any practitioner. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances. Within twenty-eight (28) days the Medical Executive Committee will either recommend discontinuation of precautionary suspension or restrictions or they will recommend summary suspension or restrictions. They may also recommend that a preliminary inquiry or a peer review investigation be initiated.

C. Continuity of Patient Care. In the event of a precautionary suspension or restriction of privileges, the affected practitioner shall immediately provide for the continuous care of the practitioner's Hospital patients by arranging for coverage by another practitioner appointed to Hospital's Medical Staff who has the appropriate credentials to care for the practitioner's patients. In the event the affected practitioner is unable or unwilling to provide for the continuous care of his patients during the period of precautionary suspension or restriction, the President of the Medical Staff and the President/CEO may make suitable arrangements.

9.05 Reserved Rights

The procedures specified herein shall not preclude the Board of Trustees from taking whatever action may be warranted by the circumstances, including precautionary suspension or restriction of privileges, termination of the investigative process, or other actions or methods for dealing with disruptive or other physician conduct which action either does not adversely affect clinical privileges, or is based on factors other than physician competence or professional conduct.

9.06 Automatic Termination

An appointment to the medical staff, as well as all clinical privileges, shall be automatically terminated upon the occurrence of any of the following events:

A. License. The practitioner's license to practice is suspended or revoked by the Board of Healing Arts, or the Board of Healing Arts imposes a condition or term of probation which restricts the practitioner's legal authority to care for patients in the usual and customary manner for the practitioner's particular specialty. If a practitioner's license is temporarily revoked, suspended, or a temporary condition is imposed, the practitioner's appointment and privileges commensurate therewith shall be deemed to be voluntarily relinquished. The practitioner shall be entitled to apply for reinstatement, and shall bear the specific burden of providing all information requested by the Hospital and, to the extent necessary, executing

releases to cause the provision of all relevant information from the Board of Healing Arts to the Hospital.

B. Sanctions. Sanctions imposed by Medicare, Medicaid, or other federal programs. If a practitioner is sanctioned by Medicare, Medicaid, or other federal program, or a temporary condition is imposed, the practitioner's appointment and privileges commensurate therewith shall be deemed to be voluntarily relinquished. The practitioner shall be entitled to apply for reinstatement, and shall bear the specific burden of providing all information requested by the Hospital and, to the extent necessary, executing releases to cause the provision of all relevant information from Medicare, Medicaid, or other federal programs, to the Hospital.

C. Termination of Affiliation with Practice Under Contract. A practitioner terminates his affiliation with a group or practice under an exclusive contract with Hospital for the provision of services customarily provided by the practitioner's specialty.

D. Failure to Report. A practitioner fails to report any restriction or condition imposed on or probation with respect to his license by the Board of Healing Arts to the Hospital within thirty (30) days of the imposition of such restriction, condition, or probation. Should a review of the circumstances reveal that the condition placed on the practitioner's license has been resolved, in consultation with the Chief of Staff, the President/CEO may waive said termination.

E. Failure to Appear. A practitioner who has been requested to appear at a meeting of any committee of the Medical Staff or Hospital in order to discuss a matter related to the practitioner's professional competence or conduct.

F. Failure to Provide Requested Information. If at any time a practitioner fails to provide required information pursuant to a formal request by the Credentials, Executive, or Ad Hoc Investigating Committees or the Board of Trustees, the practitioner's clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section "required information" shall refer to (1) physical or mental examination reports as specified elsewhere in these Bylaws, or (2) information necessary to explain an investigation or professional review action by, or resignation from, another healthcare facility or agency, or (3) any information/documentation necessary to cause an applicant to be eligible for staff appointment or privileges.

G. Action of Government Agency. A practitioner shall be deemed to relinquish any clinical privileges associated with ordering, prescribing, or administering medications or to perform investigational procedures as a result of any action on the part of the Bureau of Narcotics and Dangerous Drugs for the State of Missouri, the Drug Enforcement Administration of the United States, or the U.S. Food and Drug Administration which restricts the practitioner's legal authority to order, prescribe, or administer medications and controlled substances, to perform investigational procedures or use investigational medical devices.

9.07 Automatic Modification or Suspension of Clinical Privileges for Administrative Reasons

A. Voluntary Relinquishment of Certain Privileges and Prerogatives. Clinical privileges shall be automatically modified or suspended upon the occurrence of any of the following events. The practitioner's privilege modification or suspension may be lifted immediately upon verification that the reason for modification or suspension has been resolved.

(1) Failure to Complete Medical Records. A practitioner shall be deemed to have voluntarily relinquished certain privileges if, after having been warned of delinquency, he fails without excuse to complete medical records in accordance with Section 5.07 of the Medical Staff Rules and Regulations. The relinquishment shall run concurrently with the period of delinquency. During the period of relinquishment the practitioner is not

permitted to perform outpatient procedures or surgery, or admit inpatients, outpatients, or observation patients.

(2) Failure to Maintain Insurance. The practitioner fails to provide evidence upon request of the Hospital that the practitioner is currently insured under a policy of professional liability insurance coverage in such amounts as may be established from time to time by the Medical Executive Committee or the Board of Trustees, unless the practitioner has timely requested a waiver or reduction of such coverage requirements and is awaiting final action on such request.

(3) Failure to Comply with Proximity Requirement. A practitioner who is subject to a geographic proximity or timely response requirement who no longer meets the requirement shall be deemed to have relinquished his clinical privileges.

(4) Failure to Comply with Alternate Coverage (Backup) Requirement. A practitioner who has failed to secure/maintain and document arrangements for an alternate from the Medical Staff of Southeast Hospital to care for his patients whenever he is unable or unavailable to care for them shall be deemed to have relinquished his clinical privileges (Article III of the Medical Staff Rules and Regulations).

B. Designation of Substitute. It shall be the responsibility of the practitioner whose clinical privileges have been relinquished to designate another practitioner to serve as his substitute during the period in which the practitioner's privileges are relinquished or to provide the services for which the affected practitioner is without authority. Should the physician fail to make such appointment to provide for the continuous care of his patients, the President/CEO in consultation with the President of the Medical Staff or chairman of the affected physician's department shall appoint a physician to assume these responsibilities.

C. No Right to Hearing.

(1) The occurrences enumerated in Sections 9.06 and 9.07 (A) giving rise to automatic termination, relinquishment or modification of clinical privileges shall constitute administrative actions which are not based on a subjective determination of the professional competency or conduct of the practitioner. None of the actions enumerated in Sections 9.06 or 9.07 shall give rise to a right of fair hearing.

(2) Only adverse recommendations pertaining to clinical incompetence or unprofessional conduct give rise to the right for a fair hearing. The following are examples that do not:

(a) Issuance of a letter of guidance, warning, or reprimand
(b) Precautionary suspension
(c) Involuntary termination of temporary privileges
(d) Denial of a request for a leave of absence, or for an extension of a leave
(e) Determination that an application is incomplete
(f) Determination that an application will not be processed due to a misstatement or omission
(g) Voluntary relinquishment of staff appointment or privileges
(h) Denial of a clinical privilege because of a failure to meet established minimal threshold criteria for that privilege
(i) Ineligibility for privileges that are granted only via an exclusive contract arrangement
(j) Changing or refusing to change a staff category or department assignment

Article X
FAIR HEARING PLAN

10.01 Definitions

The following definitions, in addition to those stated elsewhere herein, apply to this Article X:

A. APPELLATE REVIEW COMMITTEE means the group designated pursuant to Section 10.06 (D) of this Article to hear a request for appellate review properly filed and pursued by a practitioner.

B. HEARING COMMITTEE means the committee appointed pursuant to Section 10.03 (C) of this Article to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

C. PARTIES means the practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review request is predicated.

10.02 Initiation of Hearing

A. Recommendations or Actions. The following recommendations or actions shall, if deemed adverse pursuant to Section 10.02 (B), entitle the practitioner affected thereby to a hearing:

(1) denial of initial staff appointment or reappointment;

(2) suspension or revocation of staff membership;

(3) denial of requested clinical privileges; or

(4) reduction, suspension (other than precautionary), revocation, or modification of clinical privileges.

B. When Deemed Adverse. A recommendation or action listed in Section 10.02 (A) shall be deemed adverse action only when it has been:

(1) recommended by the Medical Executive Committee;

(2) taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no prior right to a hearing existed; or

(3) taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

C. Notice of Adverse Recommendation or Action. A practitioner against whom adverse action has been taken pursuant to Sections 10.02 (A) and (B) shall promptly be given special notice stating:

(1) a professional review action has been proposed to be taken against the practitioner;

(2) the reasons for the proposed action;

(3) the practitioner has a right to request a Fair Hearing on the proposed action; and

(4) the time limit within which the practitioner must request a Fair Hearing.

D. Request for Hearing. A practitioner shall have thirty (30) days following receipt of a notice pursuant to Section (C) to file a written request for a hearing. Such request shall be delivered

to the President/CEO either in person or by certified or registered mail and shall be deemed filed when received by the President/CEO.

E. 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 (D) waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver in connection with:

(1) an adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board or

(2) 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. The Board shall consider the Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board shall review the information and material considered by the Committee and may consider all other relevant information received from any source. If the Board's action on the matter is in accord with the Medical Executive Committee's recommendation, such action shall constitute the final decision of the Board. If the Board's action has the effect of changing the Medical Executive Committee's recommendation, the matter shall be submitted to a joint committee as provided in Section 7.04 (H) of Article VII. The Board's action on the matter following receipt of the joint committee's recommendation shall constitute its final decision. The President/CEO shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section (E) and shall notify the President of the Staff of each such action.

10.03 Hearing Prerequisites

A. Notice of Time and Place for Hearing. Upon receipt of a timely request for a hearing, the President/CEO shall deliver such request to the President of the Medical Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. Within twenty (20) days after receipt of such request, the President of the Staff or the Board shall schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the President/CEO shall send the practitioner special notice of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than seventy-five (75) days from the date of receipt of the request for hearing.

B. Basis for Hearing. The notice of hearing required by Section (A) shall contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

C. Appointment of Hearing Committee.

(1) Arising Out of Adverse Action of the Medical Executive Committee. A hearing arising out of an adverse action of the Medical Executive Committee pursuant to Section 10.02 (B) (1) shall be conducted by a Hearing Committee comprising five impartial peers appointed by the President of the Medical Staff. No member of the Hearing Committee shall represent the department to which the investigated practitioner is associated or desires to associate and no member shall be in economic competition with the practitioner under review. No member of the hearing committee shall have participated in any preliminary inquiry or investigation preceding the Fair Hearing.

(2) Arising Out of Adverse Action of the Board. A hearing arising out of an adverse action of the Board pursuant to Section 10.02 (B) or (C) shall be conducted by a hearing

committee appointed by the President of the Board and comprising five persons. If the adverse action relates to a practitioner's professional competence or conduct, at least two Hearing Committee members shall be appointees of the Medical Staff appointed by the President of the Board in consultation with the President of the Medical Staff. Neither shall be in economic competition with the practitioner under review.

(3) Service on Hearing Committee. No practitioner or Board member shall be disqualified from serving on a hearing panel by virtue of having any previous knowledge or opinion regarding the facts in issue. All participants in any hearing committee shall perform their responsibilities in such a manner that complies with the Hospital's Statement of Organizational Ethics.

10.04 Hearing Procedure

A. Personal Presence. 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 rights in the same manner and with the same consequence as provided in Section 10.02 (E).

B. Presiding Officer. Either the hearing officer, if one is appointed pursuant to Section 10.09 (A) or the Chairman of the Hearing Committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of procedure and the admissibility of evidence. The presiding officer may hear oral arguments on procedural objections prior to hearing, and may in his discretion recess any proceeding for the purpose of considering an objection outside the presence of the Hearing Committee.

C. Pre-Hearing Procedure. The presiding officer may, but is not required to, set a pre-hearing conference to consider evidentiary matters. Parties shall exchange witness lists identifying persons who will be called to give testimony before the Hearing Committee. Unless agreed to in advance by the parties or as approved by the presiding officer, no party shall be permitted to communicate *ex parte* with any witness of the other party. The practitioner appearing before the Hearing Committee shall have a right to obtain in advance of the hearing copies of documents relevant to and considered by the body which made the recommendation for which the Fair Hearing is requested, otherwise, no party is entitled to pre-hearing discovery as a matter of right.

D. Representation by Another Practitioner. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his local professional society. The Medical Executive Committee or the Board, depending upon whose recommendation has prompted the hearing, shall appoint one of its members (or, in the case of the Medical Executive Committee, some other Medical Staff Appointee) to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provision of Section 10.09 (B).

E. Rights of Parties. During a hearing, each of the parties shall have the right to:

(1) call and ask questions of all witnesses;

(2) introduce written statements, documents, and other exhibits;

(3) request that the record of the hearing be made by a certified court reporter or that the hearing be electronically recorded.

(4) submit a written statement at the close of the hearing.

If the practitioner who requested the hearing does not testify in his own behalf, he may be called upon and asked questions.

F. Procedure and Evidence. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily reply in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law.

G. Burden of Proof. When a hearing relates to Section 10.02 (A) (1) and (3), the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendations or action lacks any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

H. Record of Hearing. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group(s) that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee chairman may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A practitioner electing an alternate method shall bear the primary cost thereof.

I. Postponement. Requests for postponement of a hearing shall be granted by the Hearing Committee only upon a showing of good cause.

J. Recesses and Adjournment. The Hearing Committee may recess the hearing 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 conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

10.05 Hearing Committee Report and Further Action

A. Hearing Committee Report. Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing.

B. Action on Hearing Committee Report. Within thirty (30) days after receipt of the report of the Hearing Committee, the Medical Executive Committee, or the Board, as the case may be, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Hearing Committee, and all other documentation considered, to the President/CEO.

C. Notice and Effect of Result.

(1) Notice. The President/CEO shall promptly send a copy of the result to the practitioner by special notice and to the President of the Board.

(2) Effect of Favorable Result.

(a) Adopted by the Board. If the Board's result pursuant to Section 10.05 (B) is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

(b) Adopted by the Medical Executive Committee. If the Medical Executive Committee's result pursuant to Section 10.05 (B) is favorable to the practitioner, the President/CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President/CEO shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section. Favorable action shall become the final decision of the Board, and the matter shall be considered closed. If the Board's action is adverse in any of the respects listed in Section 10.02 (A), the special notice shall inform the practitioner of his right to request an appellate review by the Board as provided in Section 10.06.

(3) Effect of Adverse Result. If the result of the Medical Executive Committee or of the Board pursuant to Section 10.05 (B) continues to be adverse to the practitioner in any of the respects listed in Section 10.02 (A), the special notice required by Section 10.05 (C) (1) shall inform the practitioner of his right to request an appellate review by the Board as provided in Section 10.06.

10.06 Initiation and Prerequisites of Appellate Review

A. Request for Appellate Review. A practitioner shall have fifteen (15) days following his receipt of a notice, pursuant to Section 10.05 C (2) (b) or 10.05 (C) (3) to file a written request for an appellate review. Such request shall be deemed to have been made when delivered to the President/CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

B. Waiver by Failure to Request Appellate Review. A practitioner who fails to request an appellate review within the time and in the manner specified in Section (A) waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 10.02 (E).

C. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the President/CEO shall deliver such request to the Board. The Board shall schedule and arrange for an Appellate Review which shall be not less than fifteen (15) days nor more than sixty (60) days from the date of receipt of the Appellate Review request, provided, however, that an Appellate Review for a practitioner who is under a suspension or revocation then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty-two (22) days from the date of receipt of the request for review. At least fifteen (15) days prior to the Appellate Review, the President/CEO shall send the practitioner

special notice of the date, time, and place of the review. The time for the Appellate Review may be extended by the Appellate Review Committee for good cause.

D. Appellate Review Committee. The Chairman of the Board of Trustees shall appoint five trustees to serve as the Appellate Review Committee when required. The Committee members shall elect a Chairman to serve as the presiding officer.

E. Presiding Officer. The Chairman of the Appellate Review Committee shall be the presiding officer. He, or his designees, shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

10.07 Appellate Review Procedure

A. Nature of Proceedings. The proceedings by the review committee shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that Committee's report, and all subsequent results and actions thereon. The Appellate Review Committee shall also consider the written statements submitted pursuant to Section 10.07 (B) and such materials as may be presented and accepted under Sections 10.07 (C) and (D).

B. Written Statements. The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Committee and to the President of the Medical Executive Committee through the President/CEO at least ten days prior to the scheduled date of the Appellate Review. A written statement in reply may be submitted by the Medical Executive Committee, and if submitted, the President/CEO shall provide a copy thereof to the practitioner at least three days prior to the scheduled date of the Appellate Review.

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

D. 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 may be introduced at the Appellate Review only with the approval of the Appellate Review Committee and under unusual circumstances. The Appellate Review Committee, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

E. Powers. The Appellate Review Committee shall have all powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

F. Recesses and Adjournment. The Appellate Review Committee 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 Appellate Review Committee 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.

G. Appellate Review Committee Recommendations. The Appellate Review Committee may recommend that the Board affirm, modify or reverse the adverse result or action, or, in its

discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within thirty (30) days and in accordance with its instructions. Within thirty (30) days after receipt of such recommendation after referral, the Appellate Review Committee shall make its recommendation to the Board.

H. Appellate Review Conclusion. The Appellate Review shall not be deemed to be concluded until all the procedural steps provided in Sections 10.06 and 10.07 have been completed or waived.

10.08 Final Decision of the Board

A. Board Action. Within fifteen (15) days after the conclusion of the Appellate Review, the Board shall render its initial decision in the matter in writing, and the President/CEO shall send notice thereof to the practitioner by special notice and to the President of the Staff. If this decision is in accord with the Medical Executive Committee's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the Medical Executive Committee's last such recommendation, if any, the Board shall refer the matter to a special joint committee consisting of five members of the Medical Staff selected by the President of the Medical Staff and five members of the Board selected by the Chairman of the Board for review and recommendation. The Board's action on the matter following receipt of the special joint committee's recommendation shall be immediately effective and final.

B. Special Joint Committee Review. Within thirty (30) days of its receipt of a matter referred to it by the Board pursuant to the provisions of this plan, the special joint committee shall convene to consider its recommendation to the Board.

10.09 General Provisions

A. Presiding Officer Appointment and Duties. The use of a hearing officer to preside at a hearing is optional. The use and appointment of each officer shall be determined by the Board after consultation with the President of the Medical Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He shall act in an impartial manner as the presiding officer of the hearing. If requested by the Hearing Committee, he may participate in its deliberations and act as its legal advisor, but he shall not be entitled to vote.

B. Attorneys. If the affected practitioner desires to be represented by an attorney at any Fair Hearing or at any Appellate Review appearance, his request for such Hearing or Appellate Review must so state, including the name and address of the attorney.

C. Waiver. If at any time after receipt of special notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this fair hearing plan, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he 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.

D. Number of Reviews. Notwithstanding any other provision of the Medical Staff Bylaws, no practitioner shall be entitled as a matter of right to more than one evidentiary hearing and Appellate Review with respect to an adverse recommendation or action.

E. Release. By requesting a Hearing or Appellate Review under this fair hearing plan, a practitioner (1) releases from liability and agrees to hold harmless all Hospital representatives for their acts performed in connection with peer review activities, (2) releases from liability and agrees to hold harmless all individuals, including Hospital's patients treated by the practitioner, other medical staff appointees, independent consultants engaged by Hospital and

organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the practitioner's professional competence, ability, professional conduct, character, physical condition, and mental condition as it relates to the applicant's fitness for the practice of medicine, emotional stability, ability to work with others, and other qualifications for medical staff appointment and clinical privileges.

F. Report to Board/Government Agency: In agreement with government regulations and hospital policy, final adverse actions negatively impacting the practitioner's privileges shall be reported to the appropriate regulatory boards and government agencies in compliance with their regulations through combined effort of the Vice President/Chief Medical Officer, the Chief of Staff, and the Medical Staff Services Manager.

Article XI
CONFIDENTIALITY, IMMUNITY AND RELEASES

11.01 Definitions

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

A. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matter specified in this Article.

B. MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

C. PRACTITIONER means a staff appointee or applicant, a Limited Health Practitioner, or a Physician Paramedical Employee.

D. REPRESENTATIVE means the Board and any member or committee thereof; the President/CEO; any member, officer, department, or committee of the Medical Staff; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

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

11.02 Authorizations and Conditions

By applying for, or exercising, clinical privileges or providing specified patient care services within this Hospital, a practitioner:

A. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his professional ability and qualifications.

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

C. acknowledges that the provisions of this Article are express conditions to his application for, or acceptance of, staff appointment, his exercise of clinical privileges, or provision of specified patient services at this Hospital.

11.03 Confidentiality of Information

Information with respect to any practitioner submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor used in any way except as provided herein. 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.

11.04 Immunity from Liability

A. For Action Taken. No representative of the Hospital or Medical Staff 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 duties as a representative, if such representative acts in good faith and without malice.

B. For Providing Information. No representative of the Hospital or Medical Staff and no third party shall be liable in any judicial proceedings for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or any other hospital, organization of health professionals, or other health-related organization concerning a practitioner or Limited Health Practitioner who is or has been an applicant to or appointee of the Staff, or who did or does exercise clinical privileges or provide specified services at this Hospital, provided that such representative or third party acts in good faith and without malice.

11.05 Activities and Information Covered

A. Activities. 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 health related institution or organization's activities concerning, but not limited to:

(1) applications for appointment, clinical privileges or specified services;

(2) periodic reappraisals for reappointment, clinical privileges, or specified services;

(3) corrective action;

(4) hearings and appellate reviews;

(5) patient care reviews;

(6) utilization reviews; and

(7) other Hospital, department, service, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

B. Information. The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's or limited health practitioner's professional qualifications, clinical ability, judgment, ability to work with others, character, temperament, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.06 Releases

Each practitioner or limited health practitioner shall, upon request of the Hospital, execute general and specified releases in accordance with the tenor and import of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.07 Cumulative Effect

Provisions in these Bylaws, the Policy on Limited Health Practitioners, the Organizational Manual, and any application forms relating to authorization, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

Article XII
GENERAL PROVISIONS

12.01 Medical Staff Rules and Regulations

A. Proposals by the Medical Executive Committee: Subject to the approval by the Board of Trustees, the Executive Committee of the Medical Staff shall adopt separately such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The Medical Executive Committee shall have authority to amend such Rules and Regulations subject to approval by the Board of Trustees.

Amendment to the Rules and Regulations proposed by the Medical Executive Committee will be communicated to the members of the Medical Staff for comment prior to forwarding said proposal to the Board of Trustees for action. Said proposals shall be communicated to the Medical Staff at least fourteen (14) days prior to the Medical Executive Committee meeting at which action will be taken.

B. Proposals by the Medical Staff:

(1) Any member or committee of the Medical Staff may propose an amendment to the Medical Staff Rules and Regulations by submitting a direct request to the Medical Executive Committee.

(2) Should the Medical Executive Committee not act to approve the proposed amendment:

Proposals adopted by the Medical Staff as described in Section 13.02 C of these Bylaws or by written petition containing signatures of 10% of the voting members of the medical staff may be presented directly to the Board of Trustees or to the Executive Committee of the Board at any regular or special meeting called for that purpose. The Board of Trustees shall have the option to return the matter to the Medical Executive Committee or the voting members of the Medical Staff for comment and recommendation or to undertake any other activity considered warranted prior to taking action on said proposal.

C. Provisional Adoption or Approval:

Should a documented need for urgent amendment of the Rules and Regulations exist, the Medical Executive Committee and/or the Board of Trustees may provisionally adopt and/or approve any amendment(s) necessary to comply with law or regulation at any regular or special meeting called for that purpose. Said actions provisionally taken shall be communicated to the Medical Staff for comment at least 14 days prior to the Medical Executive Committee meeting at which formal action will be taken.

Should disagreement between the Medical Executive Committee and the Medical Staff exist, the matter may be returned to the voting members of the Medical Staff, the Medical Executive Committee, or Board of Trustees for further deliberation. Conflict resolution may also be sought via Section 12.04 of these Bylaws.

D. Amendments so adopted shall be effective when approved by the Board of Trustees. Medical Staff members shall be notified of action taken by the Board of Trustees.

12.02 Medical Staff Policies

A. Proposals by the Medical Executive Committee: The Medical Executive Committee shall be authorized to adopt or amend, subject to approval by the Board of Trustees, such policies and procedures as it may deem necessary.

B. Proposals by the Medical Staff:

(1) Any member or committee of the Medical Staff may propose adoption of or amendment to Medical Staff Policies by submitting a direct request to the Medical Executive Committee.

(2) Should the Medical Executive Committee not act to approve the proposed amendment:

Proposals adopted by the Medical Staff as described in Section 13.02 C of these Bylaws or by written petition containing signatures of 10% of the voting members of the medical staff may be presented directly to the Board of Trustees or to the Executive Committee of the Board at any regular or special meeting called for that purpose. The Board of Trustees shall have the option to return the matter to the Medical Executive Committee or the voting members of the Medical Staff for comment and recommendation or to undertake any other activity considered warranted prior to taking action on said proposal.

C. Amendments so adopted shall be effective when approved by the Board of Trustees. Medical Staff members shall be notified of action taken by the Board of Trustees.

12.03 Departmental Rules and Regulations

Subject to the approval of the Medical Executive Committee and the Board, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the Rules and Regulations of the Medical Staff, or other policies of the Medical Staff or Hospital.

12.04 Conflict Resolution

When conflict exists and agreement is not reached between the Medical Staff and the Medical Executive Committee on issues including but not limited to proposals to adopt a rule, regulation, or policy or an amendment thereto, the Joint Conference Committee and four members of the Medical Staff who are not members of the Medical Executive Committee shall meet to seek resolution. The resulting resolution shall be forwarded to the Board of Trustees for final action.

Should resolution not be reached and patient care, treatment and services are at risk, the matter shall be forwarded to the Board of Trustees for further deliberation and final disposition.

Medical Staff members shall be notified of action taken by the Board of Trustees.

12.05 Professional Liability Insurance

Each practitioner granted clinical privileges in the Hospital shall maintain in force a policy of professional liability insurance in not less than the minimum amounts as from time to time may be determined by resolution of the Medical Executive Committee and of the Board, or provide other proof of financial responsibility in such manner as the Board may from time to time establish. Subject to the approval of the Board, the Medical Executive Committee may, for good cause shown by a practitioner, waive this requirement with regard to such practitioner provided that any such waiver is not granted or withheld on an arbitrary, discriminatory, or capricious basis. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the Hospital.

12.06 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices,

recommendations, reports, and other matters shall be adopted by the Board after considering the advice of the Medical Executive Committee.

12.07 Construction of Terms and Headings

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. 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.

Article XIII
ADOPTION AND AMENDMENT OF BYLAWS

13.01 Medical Staff Responsibility and Authority

The organized Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Board, Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments thereto which shall be effective when approved by the Board and shall not be in conflict with the Bylaws of the Board of Trustees. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner; reflecting the interests of providing patient care of the generally professionally locally recognized level of quality and efficiency; and maintaining a harmony of purpose and effort with the Board and with the community.

13.02 Methodology

These bylaws may be amended by (1) the combined affirmative action of the Medical Staff and the Board of Trustees, or (2) by the independent action of the Board of Trustees in the absence of prior action on amendments proposed to the Medical Staff provided such amendments have been approved by the Medical Executive Committee (Refer to 13.02 D). Any Medical Staff Appointee shall have the right to submit written comments to the Medical Executive Committee regarding the proposed amendment.

A. Proposals by Medical Staff. Any member or committee of the Medical Staff may propose an amendment to these Bylaws:

(1) By submitting a proposed amendment at any regular or special meeting of the Medical Staff,

(2) By submitting a direct request to the Accreditation and Bylaws Committee or the Medical Executive Committee,

(3) By submitting a proposed amendment at any regular or special meeting of the Board of Trustees or Executive Committee of the Board, such proposal having been adopted by the voting members of the Medical Staff as indicated in 13.02 C, (1) or (2). The Board of Trustees shall have the option to return the matter to the Medical Executive Committee for comment and recommendation prior to taking action on said proposal.

B. Proposals by Board Committee. Any Committee established by the Board of Trustees may propose an amendment to these bylaws.

C. Manner of Action by the Medical Staff. The Medical Staff may act upon proposed amendments by either of the following methods:

(1) Proposed amendments may be adopted by the Medical Staff at any regular or special meeting of the Medical Staff at which a quorum is present (ten percent of the members

eligible to vote) provided that they are included on the agenda for such meeting. Amendments proposed for consideration at a meeting of the Medical Staff shall be mailed to each member of the Medical Staff entitled to vote thereon and shall be posted on the Medical Staff Bulletin board or electronically transmitted to members of the organized Medical Staff at least fourteen (14) days prior to the Medical Staff Meeting at which they are to be considered. The affirmative vote of two-thirds of the members of the Medical Staff who are present shall be an action of the Medical Staff.

(2) Proposed amendments may be adopted by the Medical Staff by mailed ballot or by electronic means. Amendments proposed for consideration by mail ballot shall be mailed to each member of the Staff entitled to vote thereon, and ballots must be returned within thirty (30) days of mailing. At least ten percent of the members eligible to vote must return their ballots for the vote to be valid. Proposed amendments shall require the affirmative vote of at least two-thirds of the ballots returned for adoption.

Amendments so adopted by the Medical Staff shall be effective when approved by the Board of Trustees. Medical Staff members shall be notified of action taken by the Board of Trustees.

D. Action by the Board of Trustees. The affirmative vote of a majority of the Board of Trustees members eligible to vote on this matter who are present at a meeting at which a quorum is present shall be an action of the Board of Trustees.

In the event the organized Medical Staff shall fail to exercise its responsibility and authority as required by these Bylaws, and after notice from the Board to such effect including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws provided that any such amendment is first submitted to the Credentials and Executive Committees of the Medical Staff for review and comment at least thirty (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board shall be warranted shall include:

(1) action to comply with changes in federal and state laws that affect this Hospital and the Hospital corporation, including any of its entities;

(2) requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and

(3) action to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.

In such event, staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions, which shall be pursuant to these Bylaws.