ST. JOSEPH
HOSPITAL

MEDICAL STAFF BYLAWS

Approved by the Board of Directors
January 29, 2002

Last Revisions January 27, 2026

-TABLE OF CONTENTS-

ARTICLE V: MEDICAL STAFF STRUCTURE AND PERFORMANCE IMPROVEMENT FUNCTIONS

ARTICLE VI: COMMITTEES OF THE MEDICAL STAFF

ARTICLE VII: MEETINGS

ARTICLE VIII: FAIR HEARING PLAN AND APPELLATE REVIEW

DEFINITIONS

1. **ADVANCED PRACTICE PROFESSIONAL (APP)** means those individuals eligible for Privileges who provide a level of service including the evaluation and treatment of patients, documentation in the medical record, and the prescribing of medications, as applicable in accordance with each professional's scope of practice. Individuals in this category include, but are not limited to, dentists, psychologists, physician assistants (PAs), and advance practice registered nurses (APRNs).

2. **ADVANCED PRACTICE REGISTERED NURSE (APRN)** means those individuals who are certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), or nurse practitioners (NPs).

3. **ALLIED HEALTH PROFESSIONAL (AHP)** means those individuals eligible for Privileges but not Medical Staff Membership or APP status who provide a limited scope of activity that requires them to be Privileged. Individuals in this category are, but not limited to, surgical assistants and scrub techs.

4. **BOARD CERTIFIED** or **BOARD CERTIFICATION** means having been certified by the appropriate specialty board as recognized by the American Board of Medical Specialists or the American Osteopathic Association in an individual's stated area of specialized medical or surgical training.

5. **BOARD OF DIRECTORS** or **BOARD** means the governing body of St. Joseph Hospital.

6. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the Board of Directors to render specified diagnostic, therapeutic, or surgical services.

7. **DENTIST** means an individual who has been awarded the degree of Doctor of Dentistry (DDS) or Doctor of Dental Medicine (DMD).

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

9. **GOOD STANDING** refers to a Medical Staff member who is not in arrears in fees payment, and is not under suspension of appointment or admitting /or clinical privileges. Medical Staff Members in good standing shall have the prerogatives and rights provided by these Bylaws. Active Staff members in good standing shall have the right to vote, be nominated for and hold staff office or to serve as a member of the Medical Executive Committee or as a department officer or committee chair or member.

10. **HOSPITAL** means St. Joseph Hospital, Nashua, New Hampshire.

11. **HOSPITAL PRESIDENT/CHIEF EXECUTIVE OFFICER (CEO)** means the individual appointed by the Board to act on its behalf in the overall management of the Hospital. Any responsibility assigned, or authority granted to the Hospital President/CEO may be fulfilled or exercised by another administrative official of the Hospital designated by the Hospital President/CEO or the Board to perform such function.

12. **MEDICAL EXECUTIVE COMMITTEE** or **MEC** means the Executive Committee of the Medical Staff.

13. **MEDICAL STAFF** or **STAFF** means the formal organization of all duly licensed physicians, oral surgeons, podiatrists, who have been granted privileges by the Board of Directors to attend, or to otherwise serve, patients in the Hospital.

14. **MEDICAL STAFF BYLAWS** or **BYLAWS** means the Bylaws of the Medical Staff. Related Manuals means any one or more of the following documents as appropriate to the context which shall be incorporated by reference and become part of these Bylaws:

    A. Credentials Procedure Manual
    B. General Rules and Regulations and Medical Staff Policies and Procedures
    C. Advanced Practice Professional and Allied Health Professional Staff Policies and Procedures

15. **MEDICAL STAFF YEAR** means the period from January 1 through December 31.

16. **PATIENT CONTACTS** means an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an Emergency Department Practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or Practitioner in a Provider-Based Clinic.

17. **PHYSICIAN** means an individual who has been awarded the degree of Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO).

18. **PRACTITIONER** means any duly licensed physician, oral surgeon, podiatrist, APP, or AHP exercising, or applying for clinical privileges in St. Joseph Hospital, except as specifically defined in Article XII.

19. **PRESIDENT** means President of the Medical Staff.

20. **PODIATRIST** means an individual who has been awarded the degree of Doctor of Podiatric Medicine (DPM).

21. **PERFORMANCE IMPROVEMENT** is an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and others. The ongoing activities are designed to objectively and systematically evaluate the quality of patient care and services, pursue opportunities to improve patient care and services and resolve identified problems. Standards are applied to evaluate the quality of a Hospital's performance in conducting performance improvement activities. Quality of care is the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge.

22. **VICE PRESIDENT OF MEDICAL AFFAIRS (VPMA) or CHIEF MEDICAL OFFICER (CMO) VPMA/CMO** is a staff member appointed by the Hospital President/CEO whose job description includes assisting the Medical Staff leaders achieve compliance with Medical Staff Bylaws, Rules and Regulations and Policies and Procedures, as well as state, federal and accrediting agency requirements.

23. **SPECIAL NOTICE** Means a written notification hand-delivered and/or sent to a practitioner's email address provided at the time of appointment, or currently on file.

ARTICLE I - PURPOSES AND RESPONSIBILITIES

1.1 PURPOSE

The purpose of this Medical Staff is:

A. To ensure that all patients admitted to or treated in the Hospital receive optimal achievable quality patient care commensurate with Hospital resources and in accordance with the mission of Covenant Health Systems;

B. To serve as a primary means of accountability to the Board; to ensure an optimal level of professional performance of all members of the Medical Staff through the appropriate delineation of privileges and through ongoing monitoring and evaluation of clinical skills and technical performance of each staff member;

C. To provide accountability through the reporting of outcomes to the Board on patient care evaluations, continuous monitoring and other quality improvement activities in accordance with the Performance Improvement Plan;

D. To provide an appropriate educational setting that will assist in maintaining patient care standards and that will lead to continuous advancement in professional knowledge and skill;

E. To initiate and maintain Bylaws, related manuals, Rules and Regulations, Policies and Procedures for the proper functioning of the Medical Staff organization;

The Medical Staff Bylaws and related manuals shall be, and at all times remain, in conformity with the laws and statutes of the State of New Hampshire and in conformity with the Charter and Bylaws of St. Joseph Hospital of Nashua, NH, Inc. ("the Hospital Corporation"). In the event of a conflict between these Bylaws and the Charter and/or the Bylaws of the Hospital Corporation, the latter shall prevail;

F. To provide a means whereby issues concerning the Medical Staff and Hospital may be discussed by the Medical Staff with the Board and the Hospital President/CEO, and thereby provide a means through which the staff may participate in the Hospital's policy making and planning process.

1.2 RESPONSIBILITIES

The responsibilities of the Medical Staff are to account for the quality and appropriateness of patient care rendered by all members of the Medical Staff authorized to practice in the Hospital through the following measures:

A. A credentials procedure, including mechanisms for appointment, proctoring, reappointment and the delineation of clinical privileges;

B. A continuing medical education program based on the needs demonstrated through the Performance Improvement Program;

C. A utilization review program based on the requirements of the Hospital's utilization review plan;

D. An organization structure that allows continuous monitoring of patient care practices and outcomes;

E. Evaluation of the quality of patient care and the reporting of results to the Board on a quarterly basis;

F. Corrective action with respect to Medical Staff members, when warranted;

G. Enforcement of compliance with these Bylaws and related manuals, the Rules and Regulations of the Staff and other related current Hospital Policies;

H. Planning to satisfy community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;

I. Exercising the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

1.3 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of St. Joseph Hospital is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws, related manuals and associated rules and policies and procedures of the Medical Staff and St. Joseph Hospital.

1.4 QUALIFICATIONS FOR MEMBERSHIP, PROCEDURES, CONDITIONS, AND DURATION FOR AND OF APPOINTMENT, REAPPOINTMENT, INCLUDING THE PROVISIONAL PERIOD, AND DELINEATING CLINICAL PRIVILEGES

Qualifications for membership, the procedures, conditions and duration for and of appointment, reappointment, including the provisional period, the delineation of admitting and clinical privileges and actions involving Medical Staff members are set forth in these Bylaws and are further described in the Credentials Procedures Manual which is incorporated herein. The reappraisal period shall not exceed three (3) years.

1.5 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of color, national origin, membership in a protected class, gender, gender orientation, marital status or the presence of a non-related medical condition, or on the basis of any other criteria unrelated to the delivery of quality care in the Hospital setting or to professional qualifications for the Hospital's purposes, needs and capabilities. It is understood that the use of masculine gender in this document is for the sole purpose of grammatical uniformity.

1.6 MEDICAL STAFF MEMBER RIGHTS

A. Each member of the Medical Staff has the right to an audience with the Medical Executive Committee. In the event such practitioner is unable to resolve a difficulty working with his/her respective Department Chief, that practitioner may, upon presentation of a written notice to the President, meet with the Medical Executive Committee to discuss the issue.

B. Active Staff members have the right to initiate a recall election of a Medical Staff Officer or Department Chief by following the procedure outlined elsewhere in these Bylaws.

C. Any Active Staff member may call a general staff meeting upon presentation of a petition signed by ten percent (10%) of the members of the Active Staff. The Medical Executive Committee shall schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that detailed in the petition may be transacted.

D. Any Active Staff member may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event that a rule, regulation or policy is thought to be inappropriate, any practitioner may submit a petition signed by ten percent (10%) of the Active Staff members. When such petition has been received by the Medical Executive Committee, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

E. Any Medical Staff Members may request a department meeting when a majority of the members believe that the department has not acted in an appropriate manner.

F. The above sections A-E do not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging sections. Section G and the investigation, questions involving Medical Staff members, hearing and appeal plan provide recourse in these matters.

G. Any practitioner has a right to a hearing/appeal pursuant to the institution's hearing and appeal plan in the event that any of the following actions are taken or recommended:

1. Denial of Medical Staff appointment;

2. Denial of Medical Staff reappointment;

3. Revocation of Medical Staff appointment/reappointment;

4. Denial of clinical privileges or involuntary reduction of existing privileges;

5. Denial of increase in clinical privileges;

6. Application of a mandatory concurring consultation requirement (i.e., not only must the individual obtain a consult but must also reach agreement with the consult as to the course of treatment before that treatment can be pursued);

7. Suspension of staff appointment and/or clinical privileges, but only if such suspension is for longer than thirty (30) days and is not caused by the member's failure to complete medical records or other administrative reason.

ARTICLE II - BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Procedure Manual in a more expansive form.

2.1 QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Procedure Manual.

2.2 PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the Hospital President/CEO of the right to request a hearing.

2.3 PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the

Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

2.4 INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

A. Appointment and clinical privileges may be automatically relinquished if an individual:

1. Fails to do any of the following:

(a) Timely complete medical records;

(b) Provide requested information;

(c) Attend a special conference to discuss issues or concerns; or

(d) Maintain adequate professional liability insurance;

2. Has his/her license or certification to practice suspended, restricted, or revoked, or allows it to expire;

3. Has his/her controlled substance certificate revoked, suspended, or restricted, or allows it to expire;

4. Is convicted of, pleads "guilty" or "no contest" or its equivalent to a felony, or a misdemeanor related to violence or abuse, controlled substances, illegal drugs, or Medicare, Medicaid, or insurance fraud or;

5. Is excluded or precluded from participation in any state or federal health program;

6. Fails to maintain the specified amount of professional liability insurance;

7. Makes a misstatement or omission on an application form; or

8. Remains absent on leave for longer than one (1) year, unless an extension is granted by the Hospital President/CEO.

B. Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved and the individual is reinstated, if applicable. If the matter is not resolved within ninety (90) days, the individual will be required to reapply as a new applicant.

C. The MEC may recommend further corrective action in accordance with these Bylaws when any of these circumstances occur.

2.5 INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

A. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chair of a clinical department, the Hospital President/CEO or the Chair of the Board is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

B. A precautionary suspension is effective immediately and will remain in effect unless it is modified by the MEC or Hospital President/CEO.

C. The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

D. The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed fourteen (14) days.

E. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

2.6. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

ARTICLE III - CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

Categories of the Medical Staff shall include Active, Courtesy and Emeritus.

3.1.1 GENERAL QUALIFICATIONS

Each member of the Medical Staff shall meet the qualifications and responsibilities as stated in the Bylaws, Rules and Regulations and the Credentials Procedures Manual and shall support the vision, mission and commitment to the community of St. Joseph Hospital.

3.2 ACTIVE STAFF

3.2.1 QUALIFICATIONS

The Active Medical Staff shall consist of practitioners, each of whom demonstrates substantial interest in and commitment to the mission and vision of St. Joseph Hospital through patient care and Medical Staff service as evidenced by the following:

A. Contributes to the organizational and administrative activities of the Medical Staff, including Department or Committee duties as elected or appointed.

B. Actively participates in Performance Improvement/Risk Management activities as appropriate for the privileges granted pursuant to the CPM.

C. At least twelve (12) Patient Contacts per Medical Staff Year.

3.2.2. PREROGATIVES

The prerogatives of an Active Staff member shall be to:

A. Attend meetings of the Medical Staff and the Department of which they are a member, any Staff or Hospital educational programs and any committees to which they are assigned.

B. Vote on all matters presented at general and special meetings of the Medical Staff and of the Department and Committees of which s/he is a member;

C. Hold office in the Staff organization and in the Department and Committees of which s/he is a member.

3.2.3 OBLIGATIONS

In order to remain on the Active Staff, an individual shall:

A. Assume and carry out responsibility within his/her area of professional competence for the daily care and supervision of each patient in the hospital for whom s/he is providing services including completion of all necessary medical records in a timely fashion, or arrange for a suitable alternative appointee (on the Medical Staff) to provide such care and supervision during any absence or unavailability;

B. Assume reasonable service for: Emergency care (in accordance with applicable laws and regulations, including federal Emergency Medical Treatment and Active Labor Act), Medical Staff Committees and Departmental responsibilities at the discretion of the Department Chair;

C. Actively participate in recognized functions of the staff appointment including quality, performance improvement, risk management and monitoring activities including monitoring of new appointees during the provisional period and in discharging other staff functions as may be required from time to time;

D. Pay dues in an amount established by the Medical Executive Committee.

3.3 COURTESY STAFF

3.3.1 QUALIFICATIONS

The Courtesy Staff shall consist of practitioners, each of whom:

A. Do not meet the qualification criteria for Active Staff.

B. Actively participates in Performance Improvement/Risk Management activities as appropriate for the privileges granted pursuant to the CPM.

3.3.2 PREROGATIVES

The prerogatives of a Courtesy Staff member shall be to:

A. Attend meetings of the Medical Staff and the Department of which they are a member, any Staff or Hospital educational programs and any committees to which they are assigned.

B. A Courtesy Staff member shall not be eligible to vote or to hold office in the Medical Staff organization.

3.3.3 OBLIGATIONS

In order to remain on the Courtesy Staff, an individual shall:

A. Assume and carry out responsibility within his/her area of professional competence for the daily care and supervision of each patient in the Hospital for whom s/he is providing services including completion of all necessary medical records in a timely fashion, or arrange for a suitable alternative appointee (on the Medical Staff) to provide such care and supervision during any absence or unavailability;

B. Assume reasonable service for emergency care, as requested, (in accordance with applicable laws and regulations, including Federal Emergency Medical Treatment and Active Labor Act), at the discretion of the Department Chair;

C. Actively participate in recognized functions of the Staff appointment including quality performance improvement and risk management activities as appropriate for such privileges as are granted to him pursuant to the Credentials Procedure Manual.

D. Pay dues in an amount established by the Medical Executive Committee.

3.4 EMERITUS RECOGNITION

3.4.1 QUALIFICATIONS

The Emeritus Recognition is reserved for:

A. Medical Staff who are nominated by two (2) of their peers for Emeritus Recognition.

B. Medical Staff who no longer meet the qualifications for Active or Courtesy Staff and no longer have clinical privileges but are recognized for their outstanding reputations or their

noteworthy contributions to the health and medical sciences or their previous longstanding service to the Hospital.

3.4.2 PREROGATIVES

They may attend meetings of the Medical Staff and the applicable Department, any Staff or Hospital educational programs, and any committees to which they are assigned.

ARTICLE IV - MEDICAL STAFF LEADERS AND DEPARTMENTS

4.1 OFFICERS OF THE MEDICAL STAFF

4.1.1 IDENTIFICATION

The officers of the staff shall be:

A. President
B. President-Elect
C. Immediate Past President

4.1.2 QUALIFICATIONS OF OFFICERS, DEPARTMENT CHAIRS, VICE-CHAIRS AND COMMITTEE CHAIRPERSONS

A. Only those Active Staff appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, department chairs or vice-chairs and Medical Executive Committee members:

1. Be appointed in good standing to the Medical Staff and continue so during their term of office;

2. Have no pending adverse recommendations concerning staff appointment or clinical privileges;

3. Not be presently serving as a Medical Staff or corporate officer at another hospital or be employed by another hospital and shall not serve during the term of office.

B. All Medical Staff Officers, department chairs and vice-chairs and Medical Executive Committee members must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.. In addition, each Medical Staff officer, department chair/vice-chair or Medical Executive Committee member must:

1. Have demonstrated interest in maintaining quality medical care at the hospital;

2. Have constructively participated in Medical Staff affairs, including peer review activities;

3. Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;

4. Be knowledgeable concerning the duties of the office;

5. Possess written and oral communications skills; and

6. Possess and have demonstrated an ability for harmonious interpersonal relationships.

4.1.3 NOMINATIONS

A. By Nominating Committee

The Nominating Committee shall convene at least ninety (90) days prior to the Annual Meeting and shall submit to the President of the Staff a list of one or more qualified nominees for each office, to which is attached a statement of the Chair that each nominee has agreed to stand for election to office. The names of such nominees shall be posted in the staff lounge at least thirty (30) days prior to the Annual Meeting;

B. **By Petition**

Nominations may also be made by petition signed by at least twenty percent (20%) of the members of the Active Staff , to which is attached a statement signed by the nominee attesting to his willingness to stand for election to the office, and filed with the President of the staff at least seven (7) days prior to the Annual Meeting. As soon after filing of a petition as is reasonably possible, the name(s) of these additional nominee(s) shall be posted in the staff lounge;

C. **By Other Means**

If, before the election, all of the individuals nominated for an office pursuant to Sections 3.1.3 (A) and (B) shall be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit one (1) or more substitute nominees at the Annual Meeting.

4.1.4 ELECTION

Officers shall be elected at the Annual Meeting of the Medical Staff. Only Active Staff members shall be eligible to vote. Voting by proxy shall not be permitted. If there is only one (1) nominee for any office, a vote will not be conducted for the position. If there are two (2) or more nominees for any office, voting shall be conducted by secret written ballot. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes.

4.1.5 TERM OF ELECTED OFFICE

Each officer shall serve a three (3) 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.

4.1.6 REMOVAL OF OFFICERS

An officer or Medical Executive Committee member shall be removed from office if a two-thirds (2/3) majority of the Active Staff vote in favor of removal and provided that the Medical Executive Committee and the Board concur. Grounds for removal shall include, but not be limited to: Mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; an automatic relinquishment or precautionary suspension of privileges; or for conduct or statements damaging to the Hospital, its goals or programs. Action directed towards removing an officer or Medical Executive Committee member may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer or Medical Executive Committee member, signed by not less than twenty-five (25) members of the Active Staff with voting rights.

4.1.7 VACANCIES IN STAFF OFFICES

Vacancies in offices, other than that of President, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of President, the President-Elect shall become President and serve out the remaining term. In such instance, the President-Elect shall be eligible to run for the office of President after serving out the vacated term.

4.1.8 DUTIES OF ELECTED OFFICERS

A. **President**

The President of the Medical Staff shall serve as the Chief Administrative Officer and principal elected official of the staff. As such, he shall:

1. Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services and with those of the staff;

2. Be accountable to the Board, in conjunction with the Medical Executive Committee and the Vice President for Medical Affairs, for the quality and efficiency of clinical services

and performance within the Hospital and for the effectiveness of the Performance Improvement Program, Risk Management Program, and Utilization Management Program;

3. Be accountable for development and implementation, in cooperation with the Department and Committee Chairs and the Vice President for Medical Affairs, of appropriate procedures for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice and performance improvement;

4. Appoint the staff representatives to staff and Hospital committees, unless otherwise expressly provided by these Bylaws, related manuals or Hospital Bylaws, Policies or Procedures;

5. Communicate and represent the opinions, policies, concerns, needs and grievances of the staff to the Board, VPMA/CMO and the Hospital President/CEO;

6. Be responsible for the enforcement of these Bylaws and related manuals, staff Rules and Regulations, policies and procedures for implementation of sanctions where these are indicated, and for the staff's compliance with procedural safeguards in all instances where corrective action has been requested against a staff member;

7. Call, preside at, and be responsible for the agenda of all general meetings of the staff;

8. Serve as Chair of the Medical Executive Committee, and as ex officio member of all other staff committees;

9. Attend the meetings of the Board;

10. Serve as the spokesman of the staff in its external professional and public relations;

11. Be responsible for overseeing the Medical Staff's compliance with relevant accreditation standards, for providing sufficient education for and to the department chairs and vice chairs, committee chairs and reporting the accreditation status to the Medical Executive Committee, the Medical Staff and the Board;

12. Assist the Vice President of Medical Affairs in ensuring that the Medical Staff Office provides sufficient support to the Medical Staff by providing appropriate notice to all Medical Staff meetings, providing appropriately recorded minutes to each assigned Medical Staff group and assistance in follow-up to any outstanding issues.

B. President-Elect

The President-Elect shall be a member of the Medical Executive Committee. S/he shall serve on the Professional Development Committee. In the temporary absence of the President, s/he shall assume all the duties and have the authority of the President. S/he shall perform such additional duties as may be assigned by the President, the Medical Executive Committee or the Board.

4.2 DEPARTMENT OFFICERS

4.2.1 DEPARTMENT CHAIR

A. Qualifications

Each Chair shall be and remain a physician member in good standing of the Active Staff, shall have demonstrated ability in at least one (1) of the clinical areas covered by the department, and shall be willing and able to faithfully discharge the functions of his/her

office. Each Chair of a department is certified by an appropriate specialty, or affirmatively establishes comparable competence, through the credentialing process.

B. **Nomination and Election**

At least ninety (90) days prior to the Annual Meeting of the Medical Staff, the Active Staff members of each department shall nominate one (1) or more member(s) of the department who meets the qualifications of Section 3.2.1 to serve as Department Chair. The current Department Chair will transmit the name(s) of the nominee(s) to the President - Elect within seven (7) days following said nomination, but at least seventy (70) days prior to the Annual Meeting.

At least sixty (60) days prior to the Annual Meeting, the President-Elect will provide each Active Staff member with an official department-specific ballot.

The official secret ballots must be returned to the President-Elect at least thirty (30) days prior to the Annual Meeting. All department ballots will be counted by the President-Elect and one (1) other member of the Executive Committee, to be appointed by the President of the Medical Staff. The President-Elect will report the results of the department elections to the MEC at the meeting of the MEC that immediately precedes the Annual Meeting. The results will be announced to the staff at its Annual Meeting. Tie votes shall be decided by the vote of the MEC.

C. **Term of Office**

A Department Chair shall serve a term of two (2) years and until his/her successor is appointed. A Department Chair shall be eligible to serve unlimited consecutive terms if re-elected.

D. **Removal**

Removal of a Department Chair from office may be made by the Board acting upon its own recommendation or acting upon the recommendation of a simple majority vote of the department members with Active Staff appointments for the same reasons outlined in Section 4.16 for Removal of Medical Officers.

E. **Vacancy**

Upon a vacancy in the office of Department Chair, the Vice Chair of the department shall become Department Chair until a successor is elected based on the process described in Section 4.2.1B Nomination and Election.

F. **Duties**

Each Chair shall:

1. Appoint a Vice Chair;

2. Account to the Medical Executive Committee for all professional, administrative, clinically related activities and quality review functions within his department and report on a quarterly basis the quarterly Performance Improvement activities within his department including written recommendations, actions and follow-up;

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

4. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

5. Recommend clinical privileges for each member of the department;

6. Assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;

7. Be responsible for the integration of the department or service into the primary functions of the organization;

8. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;

9. Be responsible for the development and implementation of policies and procedures that guide and support the provision of services;

10. Provide recommendations for a sufficient number of qualified and competent persons to provide care or service;

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

12. Provide for the continuous assessment and improvement of the quality of care and services provided;

13. Provide for the maintenance of quality control programs, as appropriate;

14. Provide for the orientation and continuing education of all persons in the department;

15. Provide for the recommendations for space and other resources needed by the department or service;

16. Appoint such committees as are necessary to conduct and integrate the primary functions of the department;

17. Enforce the Hospital and Medical Staff Bylaws, Rules, Policies and Regulations within his department, including initiating corrective action and investigation of clinical performance and ordering required consultations;

18. Implement within his department actions taken by the Medical Executive Committee;

19. Act as presiding officer at all department meetings;

20. Perform such 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, and the Chair of the Board;

21. Develop and maintain department rules and regulations, Emergency Department coverage, and provisions for consultations or other patient care services.

4.2.2 DEPARTMENT VICE CHAIR

A. Qualifications

Each Vice Chair shall have the qualifications set forth in Section 3.2.1 (A): Active Staff Qualifications for Department Chairs and shall be appointed by the Chair.

B. **Term of Office**

A Vice Chair shall serve a term of two (2) years commencing on his/her appointment and continuing until his successor is appointed. A Vice Chair is eligible to be appointed for additional consecutive terms. Removal of a Vice Chair from office may be made by the Chair for reasons such as failure to maintain the qualifications for the position or failure to perform the duties required for the position.

C. **Vacancy**

Upon a vacancy in the office of Vice Chair, the Chair shall appoint a member of the department to fill the vacancy.

D. **Duties**

The Vice Chair shall:

1. In the absence of the Chair, carry out the duties of the Chair, and

2. Perform such duties as may be assigned by the Chair.

4.3 ADDITIONAL OFFICERS

The Board may, after considering the advice and recommendations of the Medical Executive Committee, appoint additional practitioners to medical administrative positions within the Hospital to perform such duties as are prescribed by the Board, or as defined by amendments to these Bylaws. To the extent that any such officer performs any clinical function, he must become and remain a member of the staff. In all events, s/he must be subject to these Bylaws and to the other policies of the Hospital, except to the extent so provided by the Board. CMS/DNV-required Medical Directors are to be appointed by the President/CEO with recommendation by the MEC and approval by the Board.

4.4 CONTRACTED SERVICES

At the discretion of the Hospital President/CEO, the Chair of a department which is contracted to the Hospital may be appointed, as in Section 3.2.1 (B) of these Bylaws, or may be appointed directly by the Hospital President/CEO. In all cases wherein the Chair is appointed directly by the Hospital President/CEO, the appointment/reappointment shall be reported at the MEC meeting immediately preceding the Annual Meeting of the Medical Staff. All such appointed chairs must fulfill all relevant Medical Staff qualifications and fulfill all designated responsibilities.

4.5 BOARD ACTION

All elected and appointed officials of the Medical Staff organization are subject to the approval of the governing body. The Board shall either accept the appointee or notify the staff, or the appropriate department, that it will not accept the appointee and request another nominee.

ARTICLE V - MEDICAL STAFF STRUCTURE AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.1 ORGANIZATION OF MEDICAL STAFF DEPARTMENTS

The Medical Staff shall be organized as a departmentalized staff. Each department shall have an elected Chair and an appointed Vice Chair who are entrusted with the overall responsibility of the supervision and satisfactory discharge of assigned functions.

5.2 DEPARTMENTS

A. **CURRENT DEPARTMENTS**: Are listed in the Medical Staff Rules and Regulations and Medical Staff Policies document**.**

B. **FUTURE DEPARTMENTS**: When deemed appropriate, the Medical Executive Committee may, with the Board approval, create a new, eliminate, consolidate or subdivide a department.

5.3 ASSIGNMENT TO DEPARTMENTS

Each member of the staff shall be assigned membership in one department, but may be granted clinical privileges in one or more of the other Departments. The exercise of privileges within each department shall

be subject to the Rules and Regulations therein and to the authority of the Department Chair. An Active Staff member with privileges in more than one department shall vote and attend meetings in the department in which he holds primary privileges.

5.4 FUNCTIONS OF DEPARTMENTS

The clinical departments are responsible for performing the performance improvement functions as noted below under the Medical Staff performance improvement functions. The departments:

A. May establish performance improvement subcommittees which have the responsibility and the authority to act on behalf of the department; i.e., complete departmental performance improvement activities, submit reports at least quarterly to the full department, and perform any other function which the department chair deems necessary.

B. May establish action groups as an ad-hoc committee charged with a specific responsibility to address any specific issue assigned by the full department or the PI Committee and implement a corrective action plan using the assess, plan, implement and evaluate methodology.

5.5 MEDICAL STAFF PERFORMANCE IMPROVEMENT FUNCTIONS

Performance improvement functions are the way the Medical Staff works to improve clinical and non-clinical processes that require Medical Staff leadership or participation. These functions shall be accomplished as indicated in these Bylaws through assignment to the Staff as a whole, clinical departments or divisions, to Staff committees, to Staff leaders, or other individual Staff members or to interdisciplinary Hospital committees with participation of Medical Staff members.

5.6 GOVERNANCE, DIRECTION, COORDINATION AND ACTION (Medical Staff Officers, Department Officers and Medical Executive Committee):

A. Receive, coordinate and act upon as necessary the reports and recommendations from committees, clinical units, other groups and leaders concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

B. Coordinate the activities of and policies adopted by the Staff, departments and/or divisions and committees;

C. Account to the Board and to the Staff on the overall quality and efficiency of patient care in the Hospital as documented in the findings and actions from the Medical Staff's quality assessment and performance improvement activities;

D. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted;

E. Make recommendations on medico-administrative and Hospital management matters;

F. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital;

G. Act on all matters of Medical Staff business, subject to such limitations as may be imposed by the Staff;

H. Fulfill the reporting requirements in noted in *Part 8, Section H* of the Credentials Procedures Manual.

I. Ensure that practitioners granted clinical privileges provide services only within the scope of clinical privileges granted by monitoring clinical activity and following policies and procedures defined in the Credentials Procedure Manual.

5.7 CLINICAL PERFORMANCE IMPROVEMENT ACTIVITIES

A. Adopt and modify, subject to the approval of the MEC and the Board, the Medical Staff Performance Improvement Plan and supervise the conduct of specific programs and procedures for assessing, maintaining and improving, as required, the quality and efficiency of medical care provided in the Hospital.

B. The performance of a process is dependent primarily on the activities of one (1) or more individuals with clinical privileges; the Medical Staff shall provide leadership for and participate in the process measurement, assessment, and improvement. These include, but are not limited to:

1. Medical assessment and treatment of patients,
2. Medical records review,
3. Use of medications,
4. Infection prevention and control,
5. Use of blood and blood components,
6. Utilization review,
7. Quality management systems, and
8. Significant departures from established patterns of clinical practice.

5.8 PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS

The Medical Staff shall also participate in the measurement, assessment and improvement of other patient care processes. The Medical Staff through the direction of the MEC shall conduct periodic meetings, but not less than quarterly, to analyze patient care process improvement. These include, though are not limited to:

A. Education of patients;

B. Coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and

C. Accurate, timely and legible completion of patients' medical records.

5.9 USE OF PERFORMANCE IMPROVEMENT FINDINGS

When the findings of any assessment process are relevant to an individual's performance, the MEC, in conjunction with the Hospital President/CEO, shall determine their use in peer review or the ongoing evaluations of competence, in accordance with the Credentials Policy and Procedure Manual. The findings, conclusions, recommendations and actions taken to improve organization performance shall be communicated to appropriate Medical Staff members and the MEC.

5.10 DISCHARGE PLANNING FUNCTION (Utilization Management Committee)

Participates in discharge planning activities.

5.11 CREDENTIALING FUNCTION (Credentials Committee)

A. Review, evaluate and transmit written reports as required by Credentials Policy & Procedures Manual on initial appointments, concluding or extending the provisional period, reappointments, modifications of appointment, and clinical privileges.

B. Initiate, investigate, review and report on corrective action matters according to the procedures set forth in the hearing procedures outlined in these bylaws and on any other matters involving the clinical, ethical or professional conduct of any practitioner.

C. The Credentials Committee submits written reports monthly to the MEC and the Board on the status of inordinately delayed applications and specific reasons for the same.

D. Maintain a credentials file for each member of the Staff, including records of participation in Staff activities and results of quality assessment and performance improvement activities.

5.12 EDUCATION FUNCTION

A. Participate in developing, planning, implementing, and evaluating programs of, and requirements for, continuing education that are relevant to the type and scope of patient care services delivered in the Hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to quality assessment and performance improvement activities.

B. Coordinate, as necessary, the various education activities of the staff;

C. Review the research projects and clinical investigations and maintain liaison with the Infection Control and Pharmacy functions.

5.13 INFORMATION MANAGEMENT FUNCTION (Medical Staff Officers and the Director of Information Management)

A. Review and evaluate medical records to determine that they:

1. Properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and

2. Are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital.

B. Develop, review, enforce and maintain surveillance over enforcement of Staff and Hospital policies and rules relating to medical records, including medical records completion and preparation and recommend methods of enforcement thereof and changes therein. (Medical Executive Committee)

C. Provide liaison with Hospital administration, nursing service and information management professionals in the employ of the Hospital on matters relating to medical records practices. (Medical Executive Committee)

5.14 MEDICAL STAFF ORGANIZATIONAL FUNCTIONS

Direct staff organizational activities, including staff bylaws review and revision, identifying nominees for election to the Medical Staff President and President-Elect officer positions and to other elected positions in the Medical Staff organizational structure, staff committee appointments, liaison with the Board and Hospital administration and review and assist in maintaining Hospital accreditation. (Medical Executive Committee.)

5.15 EMERGENCY PREPAREDNESS

Assist the Hospital's administration in developing, periodically reviewing and implementing crisis management manual that addresses disasters both external and internal to the Hospital. (Medical Staff Officers, Medical Executive Committee, Chair of Emergency Department)

The emergency credentialing process used by the medical staff to approve practitioners to care for patients in the event of an emergency or disaster is detailed in the Credentials Procedure Manual (see Emergency Credentialing).

5.16 PLANNING

A. Participate in evaluating existing programs, services and facilities of the hospital and Medical Staff; and recommend continuation, expansion, abridgement or termination of each. (Medical Executive Committee)

B. Participate in evaluating the financial, personnel and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment and assess the relative priorities of services and needs and allocation of present and future resources. (Medical Executive Committee)

C. Communicate strategic, operations, capital, human resources, information management and corporate compliance plans to medical staff members. (Medical Staff Officers, Medical Executive Committee, Department Chairs)

5.17 HOSPITAL-WIDE INFECTION CONTROL FUNCTION

Oversee the development and coordination of the hospital-wide program for surveillance, prevention, implementation and control of infection. (Medical Executive Committee)

5.18 HOSPITAL-WIDE PHARMACY FUNCTION

Oversee the development and surveillance of all medication utilization policies and practices within the Hospital to assure optimum clinical results and a minimum for potential hazard. Assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to medication usage in the Hospital. (Medical Executive Committee)

5.19 HISTORY AND PHYSICAL EXAMINATION AND ADMISSION NOTE

A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

COMPETENCY AND WELLNESS FUNCTION

Provide a mechanism for, manage, and oversee medical staff competency and wellness, including any necessary corrective or rehabilitative action. Medical staff committees have been established to address medical staff competency and wellness. Committee details are documented in the Rules & Regulations. The Medical Staff Health and Wellness procedure is documented in the Credentials Procedure Manual. (7/25/13)

ARTICLE VI - COMMITTEES OF THE MEDICAL STAFF

6.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the staff as may from time to time be necessary and desirable to perform the functions of the staff required by these Bylaws. All staff members to serve on committees and as committee chairs shall be appointed by the President of the staff except as otherwise provided in these Bylaws. The Hospital President/CEO shall appoint all Hospital personnel, other than staff members, to serve on committees. The President of the staff shall appoint staff members to Hospital-wide committees if requested by the Hospital President/CEO. All Committee appointments are for the Medical Staff year.

All Committees shall:

A. Maintain a record of attendance at their meetings;

B. Maintain a record of procedures;

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

D. When applicable, submit a report of ongoing activities to the Performance Improvement Committee summarizing actions, conclusions, recommendations and follow-up activities, of performance improvement activities.

6.2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of one (1) year, and shall serve until his successor is appointed. Any committee member who is appointed by the President may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by a Department Chair may be removed by a majority vote of the department or the Medical Executive Committee.

The removal of any committee member who is automatically assigned to a committee because he is a general officer or other official, shall be governed by the provisions pertaining to removal of such officer or official.

6.3 PRINCIPLES GOVERNING COMMITTEES

Any committee, whether staff-wide, department-based, standing or special that is carrying out all or any portion of a function or activity required by these Bylaws and related manuals pertaining to quality assessment or performance improvement, utilization or risk management, assessment, review or performance improvement related to the care and treatment of patients or to reduce morbidity or mortality, practitioner credentialing or otherwise for the maintenance or improvement of the quality/appropriateness or efficiency of patient care in the Hospital, is deemed a duly appointed and authorized professional and medical peer review committee of the Medical Staff and the Hospital

6.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

Representation on Hospital Committees and Participation in Certain Hospital Deliberations - Staff functions and responsibilities to liaison with the Board and administration, accreditation/licensure/certification, disaster planning, facility and services planning, financial management and functional and physical plant safety which require participation of, rather than direct monitoring by the Medical Staff, shall be performed in part by Medical Staff leaders and organizational components of the Staff as described in these Bylaws and related manuals and in part by Medical Staff representation on Hospital committees established to perform such functions. The Medical Staff, through its general staff and department chairs or their respective designees or through other organizational components, will be represented and participate in any Hospital deliberations affecting the performance of Medical Staff responsibilities.

The purpose of the Medical Staff and Hospital committees are to:

A. Perform such functions and carry out such business of the Medical Staff as may be outlined in the Medical Staff Bylaws, Rules and Regulations and related manuals;

B. Document meaningful compliance with the functions and goals defined in the Medical Staff's and Hospital's Performance Improvement Plan, provide a forum for ongoing review of clinical care rendered by the members of the Medical Staff.

C. Provide professional education of its members.

D. Improve the clinical care of patients.

6.5 EX OFFICIO MEMBERS

The Medical Staff President, the Vice President for Medical Affairs and the Hospital President/CEO or their respective designees, are ex officio members of all standing and special committees of the Staff when so designated and with vote when so specified in the provision or resolution creating the committee.

6.6 ACTION THROUGH SUBCOMMITTEE

Any standing committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, reporting such action to the MEC. Any such subcommittee may include individuals in addition to or other than members of the standing committee. The committee chairperson appoints such additional members after consultation with the Medical Staff President in the case of Medical Staff members and with the approval of the Hospital President/CEO or his designee when administrative staff appointments are to be made.

6.7 APPOINTMENT

A. Committee Chairs

Appointment of all committee chairs, unless otherwise provided for in these Bylaws, will be approved upon receiving recommendations from the President of the Medical Staff, the MEC and the Board. All chairs shall be selected from among Medical Staff members and shall have served for at least a year on the committee or otherwise have experience in the functions assigned to the

committee. Each committee chair has the right to participate in discussion of and to vote on issues presented to the committee.

Such appointments will be reviewed and endorsed by the MEC at its first meeting after the end of the Medical Staff year.

B. **Members**

Physician members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the President of the Medical Staff. There shall be no limitation in the number of terms a member may serve. A Medical Staff member may be removed from the committee for failure to maintain himself in good standing as a Staff member, or termination of an employment or contract relationship with the Hospital, loss or limitation of practice privileges, for good cause or by action of the MEC. Any ex officio member of a Staff committee ceases to be such if he ceases to hold a designated position which is the basis of ex officio membership.

C. **Vacancies**

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

6.8 **MEDICAL EXECUTIVE COMMITTEE**

There shall be a Medical Executive Committee composed of the officers of the staff, the Chair of each Department, Chair of the Credentials Committee, Medical Director of Hospitalist Program, and four (4) members of the Active Staff, elected for a two (2) year term at the Annual Meeting of the staff. After the adoption of these Bylaws, two at-large members of the staff are to be elected for a one (1) year term and two (2) at-large members are to be elected for a two (2) year term. Thereafter, at each Annual Meeting, two at-large members of the staff are to be elected to serve a two (2) year term. There shall be an APP member appointed to the MEC by the President of the Medical Staff. The APP will have voting privileges. The term shall be 2 (two) years. Vacancies will be appointed by the President of the Staff. The Hospital President/CEO, VPMA/CMO, nursing executive, and VP of Patient Care Services shall serve as ex-officio members, without vote. The Medical Staff Coordinator shall attend as staff.

A. The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The duties of the Medical Executive Committee shall be to:

1. Receive and act upon reports and recommendations from the departments, committees and officers of the staff concerning the findings of the performance improvement/utilization management program and other performance improvement activities 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 appointments, reappointments, staff category, department assignments, clinical privileges, disciplinary 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. Initiate and pursue corrective action, when warranted, in accordance with these Bylaws;

6. Make recommendations on medico-administrative and Hospital management matters to the Board through the Hospital President/CEO;

7. Make recommendations to the Board on at least the following: The Medical Staff structure, the mechanism used to review credentials and to delineate individual clinical privileges for each eligible individual; the mechanism by which Medical Staff membership may be terminated and the mechanism for fair hearing procedures;

8. Inform the staff of the accreditation program and the accreditation status of the Hospital;

9. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

10. Represent and act on behalf of the staff, subject to such limitations as may be imposed by these Bylaws;

11. The Medical Executive Committee is responsible for assuring the appropriate performance of Medical Staff performance improvement/risk management activities in all its departments and committees and is accountable to administration and the Board of Directors to ensure that these activities are performed. It delegates the responsibility for the planned systematic, ongoing process of monitoring and evaluation of the quality and appropriateness of care to each department and to the Department Chair. It assists the Department Chairs with corrective actions concerning individual practitioners with identified problems. It will ensure that the performance improvement reviews are done, problems identified and corrective actions are taken and that documentation of all these activities are completed in a timely manner, and if necessary make recommendations to take action and perform follow-up;

12. The Committee Chairs and Department Chairs are accountable to the Medical Executive Committee by conforming to the requirements set forth and by actively participating in the Performance Improvement Program. A summary of the minutes of the meetings shall be presented at each general staff meeting.

B. Meetings

The MEC shall meet at least ten (10) times a year or more often if necessary to fulfill its functions. It shall maintain a permanent record of its proceedings and actions and shall report to the Board of Directors.

6.9 ADDITIONAL MEDICAL STAFF COMMITTEES

The additional Medical Staff Committees are described in the Medical Staff Rules and Regulations/Policy and Procedure Manual.

ARTICLE VII- MEETINGS

7.1 GENERAL STAFF MEETINGS

A. Regular Meetings

The staff shall hold regular staff meetings on the third Tuesday of March, June, September, and December of each year. The December meeting constitutes the Annual Meeting, at which the election of officers and staff members to certain committees for the following Medical Staff year shall be conducted.

B. Special Meetings

Special meetings of the staff may be called at any time by the Board, the President of the staff, the Medical Executive Committee, or shall be called by the President of the staff within thirty (30) days after receipt of a written request by at least twenty-five percent (25%) of the members 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.

7.2 COMMITTEE AND DEPARTMENT MEETINGS

A. Regular Meetings

Committees and departments may, by resolution, provide for 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. Each chairman shall make every reasonable effort to ensure that the meeting dates are disseminated to the members with adequate notice.

B. Special Meetings

A special meeting of any committee or department may be called by, or at the request of:

1. The Chair thereof;
2. The Board;
3. The President of the Medical Staff; or
4. At least thirty-three percent (33%) but no less than three (3) of its current members.

The meeting shall be held within thirty (30) days after receipt of written request.

No business shall be transacted at any special meeting except that stated in the meeting notice.

7.3 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any general staff meeting, or any special meeting or of any regular committee, department or service meeting not held pursuant to resolution shall be posted in the Medical Staff lounge, on the hospital's website or delivered to each person entitled to be present not less than two (2) days before the date of such meeting. Notice of department and committee meetings may be given orally. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

7.4 QUORUM shall be:

A. General Staff Meetings

Those Active Staff members present and eligible to vote (including at least two (2) Active Staff Medical Staff members) shall constitute a quorum for general staff meetings.

B. Department and Committee Meetings

Those members of a department or committee present and eligible to vote, including at least two (2) Active Medical Staff members, shall constitute a quorum at any meeting of such department or committee. Members specifically described as ex-officio shall not be counted in determining the presence of a quorum.

C. Credentials and Medical Executive Committee Meetings

Twenty-five percent (25%) of the members of the Credentials or Medical Executive Committees will constitute a quorum in matters of credentialing. In matters pertaining to policy, a fifty percent (50%) quorum is necessary.

7.5 MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting, which includes at least two (2) staff members with voting privileges, at a meeting at which a quorum is present, shall be the action of the group. Action may be taken without a meeting by a department or committee by a writing setting forth the action so taken signed by each member entitled to vote there at. Members of committees appointed by the Hospital President/CEO in conformity with Section 5.1 shall not have the same rights and privileges as members of the staff serving on the committees, including the right to vote.

7.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance, the recommendations made and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees at subsequent meetings, forwarded to the Medical Executive Committee and made available to the staff. The Medical Staff Office shall maintain a permanent file of minutes from the Medical Executive, Credentials, Bylaws, and General Staff meetings as well as all other Medical Staff department and committee minutes.

7.7 ATTENDANCE REQUIREMENTS

A. Regular Attendance

Each member of the Active Staff shall be encouraged to attend each year:

1. At least fifty percent (50%) of all staff meetings duly convened pursuant to these Bylaws; and

2. At least fifty percent (50%) of all meetings of each department and committee of which he is a member.

Members appointed to the Courtesy Staff or any Allied Health Professional, Advanced Practice Professional, or practitioner recognized as Emeritus shall be encouraged to attend and participate in departmental meetings and any committees of which s/he is a member.

B. Special Appearance

A member of any category of the Medical Staff whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be given special notice, at least fourteen (14) days prior to the meeting, which shall include a statement of the issue involved and that the staff member's appearance is mandatory. Failure of the staff member to appear at any meeting with respect to which he was given such special notice shall, unless excused by the Medical Executive Committee upon showing a good cause, result in an automatic relinquishment of all or such portion of the staff member's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or the Board, or through corrective action if necessary. Any other staff members assigned to discuss a patient's clinical course of treatment at a regular departmental or committee meeting shall receive notice and appear in a like manner as described above.

ARTICLE VIII - FAIR HEARING PLAN AND APPELLATE REVIEW

8.1 INITIATION OF HEARING

A practitioner is entitled to request a hearing when the Medical Executive Committee has recommended any of the following actions which diminish the practitioner's ability to admit or treat patients, or when the Board of Directors takes such action contrary to a favorable recommendation of the Medical Executive Committee or when the Board of Directors takes such action on its own initiative without benefit of a prior recommendation by the Medical Staff ("initiating body"):

A. Denial of Medical Staff appointment;

B. Denial of Medical Staff reappointment;

C. Revocation of Medical Staff appointment/reappointment;

D. Denial of clinical privileges; or involuntary reduction or limitation of existing privileges;

E. Denial of increase in clinical privileges;

F. Application of a mandatory concurring consultation, when such requirement only applies to an individual Medical Staff member;

G. Suspension of staff appointment and/or clinical privileges, but only if such suspension is for longer than thirty (30) days and is not caused by the member's failure to complete medical records or other administrative reason.

No other recommendations except those enumerated above shall entitle the individual to request a hearing. The hearing and appeal process for non-practitioners is described in the Credentials Procedure Manual.

8.2 NOTICE OF RECOMMENDATIONS

When a recommendation is made, which according to this plan, entitles an individual to a hearing prior to a final decision of the Board of Directors, the affected individual shall promptly be given notice by the Hospital President/CEO, in writing, certified mail, return receipt requested. This notice shall contain:

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

B. Notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of the receipt of the notice; and

C. A copy of this Article outlining the rights in the hearing as provided for in this policy.

8.3 REQUEST FOR HEARING

Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Hospital President/CEO or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made, and such recommended action shall thereupon become effective immediately upon final Board action.

8.4 NOTICE OF HEARING AND STATEMENT OF REASONS

A. If the affected individual submits a timely request for a hearing as described above, the Hospital President/CEO shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The notice shall include:

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

2. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the initiating body, at the hearing;

3. The name of the Hearing Panel members and Presiding Officer or Hearing Officer, if known; and

4. A statement of the specific reasons for the recommendation as well as the list of patient record numbers and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and the individual's counsel have sufficient time to study this additional information and rebut it.

B. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

8.5 WITNESS LIST

At least fifteen (15) days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf. The list of witnesses who will testify in support of the initiating body will include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses.

8.6 HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER

A. Hearing Panel

1. When a hearing is requested, the Hospital President/CEO, acting for the Board and after considering the recommendations of the President of the Medical Staff (and that of the Chair of

the Board, if the hearing is occasioned by a Board determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The Hearing Panel shall be composed of individuals who shall not have actively participated in the consideration of the matter involved at any previous level or of physicians or laypersons not connected with the hospital or any combination of such persons. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

2. The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected individual. Such appointment shall include designation of a Chairperson or a Presiding Officer.

3. Any objection to any member of the Hearing Panel or the Hearing Officer or Presiding Officer shall be made in writing within ten (10) days of receipt of the notice to the Hospital President/CEO who shall resolve the objection.

B. **Presiding Officer**

1. In lieu of a Hearing Panel Chairperson, the Hospital President/CEO may appoint an attorney at law as Presiding Officer. Such Presiding Officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

2. If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall be appointed by the Hospital President/CEO to serve as the Presiding Officer, and shall be entitled to one (1) vote.

3. The Presiding Officer (or Hearing Panel Chair) shall:

(a) Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

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

(c) Maintain decorum throughout the hearing;

(d) Determine the order of procedure throughout the hearing;

(e) Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

(f) Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations;

(g) Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the panel wishes to be present; and

(h) The Presiding Officer or the Hearing Panel Chairperson may be advised by legal counsel to the hospital.

8.7 **PRE-HEARING AND HEARING PROCEDURE**

A. There is no right to formal "discovery" in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request, to the following subject to a stipulation

signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

1. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

2. Reports of experts relied upon by the initiating body;

3. Copies of redacted relevant committee or department minutes; and

4. Copies of any other documents relied upon by the initiating body.

B. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with the proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good causes.

C. Prior to the hearing, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the initiating body, copies of any expert reports or other documents upon which the individual will rely at the hearing.

D. There shall be no contact by the physician with hospital employees appearing on the hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

8.8 PROVISION OF RELEVANT INFORMATION

The Presiding Officer shall require a representative for the affected individual and for the initiating body to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to the exhibits or witnesses and determine the time to be allotted to each witness' testimony and cross examination. The Presiding Officer may specifically require that:

A. All documentary evidence to be submitted by the parties will be presented at this conference; any objections to the documents shall be made at that time and the Presiding Officer shall resolve such objections;

B. Evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges be excluded;

C. The names of all witnesses and a brief statement of their anticipated testimony be submitted if not previously provided;

D. The time granted to each witness' testimony and cross-examination will be agreed upon or determined by the Presiding Officer, in advance, and;

E. Witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing; and

F. No information shall be provided regarding other practitioners.

8.9 FAILURE TO APPEAR

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action.

8.10 RECORD OF HEARING

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of New Hampshire;

8.11 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

A. Call and examine witnesses to the extent available;

B. Introduce exhibits and any relevant evidence;

C. Cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

D. Representation by counsel who may call, examine and cross examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the hearing; and

E. To submit a written statement at the close of the hearing;

If the practitioner who requested the hearing does not testify in his/her own behalf, s/he may be called and examined as if under cross-examination, subject to invocation of any applicable legal privilege.

The Hearing Panel may question the witnesses, call additional witnesses and/or request documentary evidence if it deems appropriate.

8.12 ADMISSIBILITY OF EVIDENCE

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

8.13 POST-HEARING MEMORANDA

Each party shall be entitled to submit a post hearing memorandum and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing.

8.14 OFFICIAL NOTICE

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

8.15 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the Presiding Officer or the Hospital President/CEO on a showing of good cause.

8.16 ORDER OF PRESENTATION

The initiating body shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

8.17 BASIS OF RECOMMENDATION

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the hearing panel shall recommend in favor of the initiating body unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

A. Oral testimony of witnesses;

B. Briefs, or memoranda of points and authorities presented in connection with the hearing;

C. Any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

D. Any and all applications, references and accompanying documents;

E. Other documented evidence, including medical records; and

F. Any other evidence admitted at the hearing.

8.18 ADJOURNMENT AND CONCLUSION

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of oral and written evidence by the parties and questions by the Hearing Panel, the hearing shall be closed.

8.19 DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL

Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons for the recommendation.

8.20 DISPOSITION OF HEARING PANEL REPORT

The Hearing Panel shall deliver its report and recommendation to the Hospital President/CEO who shall forward it, along with all supporting documentation, to the Board for further action. The Hospital President/CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Medical Executive Committee for information and comment.

8.21 TIME FOR APPEAL

Within ten (10) days after notice of the Hearing Panel's recommendation, either the affected individual or the initiating body may appeal the recommendation. The request for appellate review shall be in writing and shall be delivered to the Hospital President/CEO either in person or by certified mail, return receipt requested, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

8.22 GROUNDS FOR APPEAL

The grounds for appeal shall be limited to the following:

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

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

8.23 TIME, PLACE AND NOTICE

Whenever an appeal is requested as set forth in the preceding section, the Chairperson of the Board shall take action to schedule and arrange for an appellate review to be held as soon as arrangements can reasonably be made, taking into account the schedules of all individuals involved, after receipt for such request. The affected individual shall be given notice of the time, place and date of the appellate review. The Appellate Review Panel shall be convened not less than ten (10) days, nor more than thirty (30) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for an appellate review. The time for appellate review may be extended by the Chairperson of the Board for good cause.

8.24 NATURE OF APPELLATE REVIEW

A. The Chairperson of the Board shall appoint a Review Panel composed of not less than three (3) members of the Board to consider the record upon which the recommendation before it was made.

B. The Review Panel may accept additional oral or written evidence subject to the same rules of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

C. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument limited to thirty (30) minutes per side. The Review Panel shall recommend final action to the Board.

D. The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own recommendation based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

8.25 FINAL DECISION OF THE BOARD

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its actions, and shall deliver copies thereof to the affected individual and to the President of the Medical Staff, in person or by certified mail, return receipt requested.

8.26 FURTHER REVIEW

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

8.27 RIGHT TO ONE APPEAL ONLY

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one (1) hearing or one (1) appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that

individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this hospital unless the Board approves otherwise.

ARTICLE IX - BOARD APPROVAL AND INDEMNIFICATION

Any Medical Staff officer, department chair, committee chairperson, committee member and individual staff appointee who acts for and on behalf of the Hospital in discharging duties, functions or responsibilities stated in these Medical Staff Bylaws and related manuals, shall be indemnified to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board of Directors.

ARTICLE X - CONFIDENTIALITY, IMMUNITY AND RELEASE

10.1 SPECIAL DEFINITIONS

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

A. "Information" means all acts, communication, records or proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written, computerized or oral form.

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

C. "Representative" means the Board and any member or committee thereof, the Hospital President/CEO, the staff organization and any member, officer, department, service or committee thereof and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

D. "Third Parties" means both individuals and organizations providing information to any representative.

10.2 CONFIDENTIALITY OF INFORMATION

Information submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of: Assessing, reviewing, evaluating, monitoring or improving the quality and efficiency of health care provided; evaluating current clinical competence and qualifications for staff appointment/affiliation, or clinical privileges for specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, be confidential. This information shall not be disseminated to anyone other than a representative of the hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information of like kind that may be provided by third parties. Each practitioner expressly acknowledges that violation of the confidentiality provided here is grounds for immediate and permanent revocation of staff appointment and/or clinical privileges for specified services.

10.3 GRANT OF IMMUNITY AND AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

A. Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties

in the course of credentialing and peer review activities. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

B. **Authorization to Obtain Information from Third Parties:**
The applicant authorizes the Hospital, Medical Staff leaders, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request.

C. **Authorization to Release Information to Third Parties:**
The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

D. **Hearing and Appeal Procedures:**
The applicant agrees that the hearing and appeal procedures set forth in this Manual shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

E. **Legal Actions:**
If, notwithstanding the provisions in this Section, an applicant institutes legal action challenging any professional review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

10.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this article applies to all information or disclosures performed or made in connection with this or any other educational or health care facility's or organization's activities concerning, but not limited to:

A. Applications for appointment/affiliation, clinical privileges or specified services;

B. Periodic reappraisals for renewed appointment/affiliation, clinical privileges and specified services;

C. Corrective or disciplinary actions;

D. Hearings and appellate reviews;

E. Quality assessment and performance improvement activities;

F. Utilization reviews;

G. Claims reviews;

H. Risk management and liability prevention activities; and

I. Other hospital, department, service, committee and subcommittee activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article.

10.6 CONFLICTS RELATED TO MEDICAL STAFF FUNCTIONS

When performing a function outlined in these Bylaws and related manuals, if any Medical Staff appointee has or reasonably would be perceived as having a conflict of interest or bias in any matter involving another

individual related to the function being performed, the conflicted member shall first declare the conflict and shall not vote on the matter. However, the individual may be asked and may answer any questions concerning the matter.

Any other member with knowledge of such may call the existence of a potential conflict of interest or bias on the part of any member to the attention of the Medical Staff President. The Medical Staff President shall have a duty to delegate the performance of the function in question to another member when a conflict of interest is disclosed or is reasonably perceived to exist.

10.7 HOSPITAL CONFLICT OF INTEREST POLICIES

Members of the Medical Staff who have interests outside the hospital and their own personal practice which have or might reasonably create a conflict of interest with the hospital or with their membership on the Medical Staff or its committees, shall submit to the Medical Executive Committee a statement concerning the name and address of the organization and the nature of the interest.

Medical Staff members shall also be bound by corporate conflict of interest policies adopted by the Board and the Hospital's parent company, Covenant Health, Inc., to the extent those policies apply to the Medical Staff member in question.

ARTICLE XI - GENERAL PROVISIONS

11.1 STAFF RULES AND REGULATIONS AND/OR POLICIES AND PROCEDURES

The Medical Staff shall adopt such policies, procedures, rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these bylaws. The policies, procedures, rules and regulations shall be related to the proper conduct of Medical Staff organizational activities and will embody the specific standards and level of practice that are required of each Medical Staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the Hospital. Such rules and regulations may be amended or repealed upon recommendation of the Medical Executive Committee and approval by the Board of Directors.

Medical Staff policies may also be adopted, amended or repealed upon recommendation of the Medical Executive Committee with final approval by the Board of Directors.

11.2 DEPARTMENT POLICIES AND PROCEDURES

Subject to the approval of the Medical Executive Committee and the Board, each department may formulate its own policies and procedures for the conduct of its affairs and the discharge of its responsibilities. Such policies and procedures shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Staff, or other policies of the Hospital. A permanent file of current department policies and procedures shall be maintained by the Medical Staff Office.

11.3 FORMS

Application forms and any other prescribed forms required by these Bylaws and related manuals for use in connection with Staff appointments, re-appointments, 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.

11.4 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 contest and circumstances require. 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.

11.5 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital President/CEO.

ARTICLE XII - ADOPTION AND AMENDMENT OF BYLAWS, CREDENTIALS PROCEDURE MANUAL AND MEDICAL STAFF RULES AND REGULATIONS

12.1 MEDICAL STAFF BYLAWS

A. Neither the MEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

B. Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least ten percent (10%) of the voting members of the Medical Staff.

C. All proposed amendments to these Bylaws must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least fourteen (14) days prior to the meeting. To be adopted, (i) a quorum of at least ten percent (10%) of the Active Staff must be present, and (ii) the amendment must receive a majority of the votes cast by the Active Staff at the meeting.

D. The MEC may also present proposed amendments to these Bylaws to the Active Staff by written ballot or e-mail, to be returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least ten percent (10%) of the Active Staff, and (ii) an amendment must receive a majority of the votes cast.

E. The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling, or other errors of grammar or expression.

F. All amendments shall be effective only after approval by the Board.

G. If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Hospital President/CEO within two (2) weeks after receipt of a request.

12.2 OTHER MEDICAL STAFF DOCUMENTS

A. In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents are the Medical Staff Credentials Procedure Manual and the Medical Staff Rules and Regulations.

B. An amendment to the Medical Staff Credentials Procedure Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each Active Staff member of the Medical Staff at least fourteen (14) days prior to the MEC meeting when the vote is to take place. Any Active Staff member may submit written comments on the amendments to the MEC.

C. The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all

provisionally adopted amendments shall be provided to each member of the Active Staff as soon as possible. The Active Staff shall have fourteen (14) days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below shall be implemented.

D. All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

E. Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least ten percent (10%) of the Active Staff members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Board for its final action.

F. Adoption of, and changes to, the Medical Staff Credentials Procedure Manual, the Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

12.3 CONFLICT MANAGEMENT PROCESS

A. When there is a conflict between the Medical Staff and the MEC with regard to:

1. Proposed amendments to the Medical Staff Rules and Regulations;

2. A new policy proposed or adopted by the MEC; or

3. Proposed amendments to an existing policy that is under the authority of the MEC,

A special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least ten percent (10%) of the Active Staff members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

B. If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Active Staff members of the Medical Staff, to the Board for final action.

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

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

E. In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to an ad hoc Joint Conference Committee established for the purposes of addressing the conflict, composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

Original Approvals:

Robert Quirbach, MD	12/10/01
President of the Medical Staff	Date
Suzanne Forget	1/29/02
Secretary of the Board	Date

Amended:

Bylaws Committee 2/3/04; MEC 2/10/04; Medical Staff 3/16/04; BOD 3/30/04

Bylaws Committee 5/25/04; MEC 6/8/04; BOD 6/29/04

Bylaws Committee 2/15/05; MEC 3/8/05; Medical Staff 3/15/05; BOD 3/29/05

Bylaws Committee 11/16/06

Bylaws Committee 2/14/07; MEC 3/13/07; Medical Staff 3/20/07; BOD: 03/27/07

Bylaws Committee 08/09; MEC 11/10/09; BOD 11/24/09; Medical Staff 12/15/09

Bylaws Committee 10/25/2011; MEC 11/08/2011; BOD 11/29/11; Medical Staff 12/20/11

MEC 7/10/12; BOD 8/7/12; Medical Staff 12/18/12

Bylaws Committee 4/13; MEC 5/14/13; Medical Staff 6/18/13; BOD 6/25/13

Medical Staff Approval 12/16/25, MEC Approval was 1/8/26, Board Approval to 1/27/26